VOLUME 1

NUMBER 2

JOURNAL

OF THE

FORT LOGAN

MENTAL HEALTH CENTER

WINTER 1963

The Journal of the Fort Logan Mental Health Center is a quarterly, scientific journal which publishes original articles on new treatment methods of emotional disturbances, with emphasis on hospital community psychiatry and therapeutic milieu.

Yearly subscriptions may be obtained free of charge. Manuscripts, orders, and change of address notices should be sent to Editor, Journal of the Fort Logan Mental Health Center, Box 188, Fort Logan, Colorado.

PUBLISHED BY

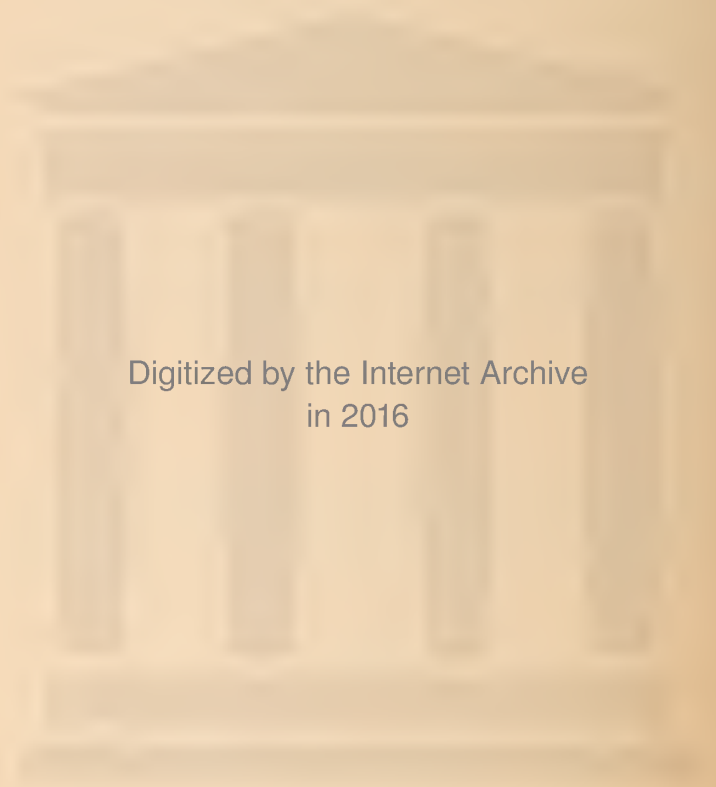
Fort Logan Mental Health Center
Alan Kraft, M.D., Director

Department of Institutions
David Hamil, Director

State of Colorado
John Love, Governor

Application to mail at Second Class Postage rates is pending at Fort Logan, Colorado.

WINTER CONTENTS 1963



The Fort Logan Mental Health Center is a new state hospital which will eventually serve half of the population of the state of Colorado. Its organization follows as much as possible the recommendations of the Joint Commission on Mental Illness and Health. Concepts of milieu therapy are strongly utilized, with the emphasis on expansion of professional roles and the involvement of the patient's family and his community as much as possible in treatment. The hospital is entirely open and relies heavily on transitional forms of treatment. One-half of its patients are in day care, and evening care is being instituted. Geographic and administrative decentralization are utilized, with the same psychiatric team following the patient through admission, treatment, and outpatient care.

CONSIDERATIONS IN PLANNING PSYCHIATRIC WARDS IN GENERAL HOSPITALS

JOHN CUMMING, M.D.,* *Director*
Mental Health Research Unit
New York State Department of Mental Hygiene, Syracuse, New York

Within the last two years, two national bodies have recommended extensive programs of construction of psychiatric wards in general hospitals. The first of these, the Joint Commission on Mental Illness and Health (1), recommended that no community general hospital should be regarded as rendering a complete service unless it accepts mental patients for short-term hospitalization and therefore provides a psychiatric unit or psychiatric beds. Each community general hospital of one hundred or more beds should make this provision. A hospital with such facilities should be regarded as an integral part of a total system of mental patient services in its region. The report goes on to state that definitive care for patients with major mental illnesses should be given in such units.

On March 9, 1961, Mr. Enoch Powell, the Minister of Health in Great Britain, spoke to the National Association for Mental Health and called for bold planning of future hospitals with provision for mental illness. Looking forward to the mid-seventies, he estimated that not more than half the present places for mental illness would be likely to be needed at that time. These places, he felt, ought to be mostly within general hospitals rather than great isolated institutions. While he realized that this would mean the elimination of most of their present mental hospitals and the construction of a large number of relatively small treatment units in general hospitals, he put this forward as a policy for the future.

In Great Britain the agency which is proposing the changes is also the one which will be paying for them, whereas in the United

*333 E. Washington Street, Syracuse 2, New York.

Journal of the Fort Logan Mental Health Center, Vol. 1, pp. 59-69.

States the proposal is that "someone" should undertake these changes. Perhaps because of this, there has been much more controversy and discussion about the proposed changes in Great Britain than there has been in the United States. In the first place, the estimates of future needs for mental hospital beds have been attacked from many points of view with widely differing estimates resulting. In effect, some epidemiologists believe that the decline in mental hospital populations which we have experienced over the past six years will continue and even accelerate. Others, including some who were pioneer innovators in the development of the present changes, are taking a much more conservative view and feel that within a relatively short space of time we will arrive at a new plateau in hospital populations where the decrease will stop and where we may even experience some slight increases again. The drastic conversion which has been recommended is based upon a faith that we can deal effectively with our mentally ill in acute treatment units and that they will not at any time in the future require prolonged treatment in custodial institutions. Since this assumption is as yet untested, it might be financially wise to proceed with some caution.

It is interesting to examine the sharp reaction of a number of psychiatrists to these proposals. Cohen and Haldane (3) in a recent article pointed out that the physical and interpersonal environment of the hospitalized psychiatric patient should be considerably different from that of the patient who has a physical illness. They point out that the physically ill patient is admitted to a general hospital usually because his illness requires some technical procedure that cannot well be carried out at home. It is considered unfortunate that he must be separated from his normal environment. Usually a psychiatric patient is not admitted for a technical procedure. Often the patient has been sent to the hospital in the hope that from his experience there he will gain enough insight into the nature, motives, and effects of his social behavior to modify it so that he can be able to tolerate and be tolerated by his usual social environment. In order to have the opportunity to do this, the psychiatric ward must indeed be a very active place. The patient should be engaged in activity for nearly his whole day, and his activities should be carried out with other patients, nurses, occupational therapists, and other clinicians who have a stable relation-

ship with him. For these reasons they point out that the psychiatric areas will need high staff-patient ratios and that there should be very little interchange of this staff with staff in other areas of the hospital. Since the staff must work as a team, it is unlikely that it will be effective if the psychiatric direction comes from private practitioners who spend only a short period of time each day in the hospital. The minimal requirement should be a competent full-time psychiatrist for every ward, and the author feels that these units work best when all the senior staff members are permanent salaried employees of the hospital. Even the better private hospitals have in many cases found that a good program cannot operate unless the private practitioner who wishes to hospitalize his patient is prepared to surrender his authority over the patient's daily living experience. He may in most of these cases come to the hospital and see the patient for a psychotherapeutic hour, but the patient's daily life must be scheduled with the needs of all patients firmly in mind.

It can easily be seen that the amount of activity which is implied by this recommended program cannot be carried out in the amount of space provided in traditional hospital settings for the usual kind of patients who are up and about. As Cohen and Haldane suggest, there should be a room large enough for all patients to meet as a group and to join in social activity, where others, such as former patients and perhaps relatives, can join them on occasion. There should be smaller rooms for occupational therapy groups and there should also be provisions for a degree of privacy and quietness. Some extra space is needed so that acutely disturbed patients can be separated. They also might have added the need for room for workshops where remunerative employment can be carried on. Finally, there should be easy access to the outdoors and sufficient space for outdoor recreation.

In the light of this, we should perhaps consider McKeown's (6) proposal to use some type of domestic architecture in the construction of units for the care of the psychiatrically ill. Such units are considerably cheaper to construct, they provide for some separation from the main hospital building, which is often useful, and their rate of deterioration is probably high, a useful thing when treatments are changing as rapidly as they are in the field of psychiatry.

What questions should be asked before opening a psychiatric ward? The author will list several of these and some of the factors which perhaps should be considered in attempting to answer them.

1. What are the particular groups within the mentally ill of the community which the service is designed to service? The acute psychotic person in the police court who needs assessment, the alcoholic, the delinquent with behavior disorders, and the patient with recognized psychosomatic conditions represent a few of the groups for whom services are inadequate in most communities. Not only does each one of these groups need special facilities, but the pressures which may bring a psychiatric ward into existence in a hospital come from several sources. There are pressures from the community to get a facility which will deal with groups which are creating difficulty and embarrassment because of the nature of their actions. At the same time, there is usually pressure from psychiatrists who would like to have an additional facility for use in their own practices. Unfortunately, this often results in a facility being created for one purpose and used for another with eventual disillusionment on the parts of one or the other of the proponents. A parallel situation has arisen in the establishment of outpatient psychiatric clinics. At one time, outpatient psychiatric clinics were proposed to the American public as a solution to the increasing problem of the number of people who were being sent to state hospitals. However, in a recent survey of clinics in New York State, Forstenzer (5) has estimated that only one and a half per cent of the patients seen in these clinics were referred from state hospitals, and only two per cent were referred on to state hospitals. Thus the state hospital and the mental health clinic seem to be dealing with two different populations. This is probably the reason for the observed lack of effect of the establishment of mental hygiene clinics upon the rate of people seeking help from state hospitals. It may also account for some of the present disillusionment on the part of those who are paying the costs for the operation of some of our clinics.

2. What is the financial base for paying for a particular service which is contemplated? If this is not considered and agreed upon in advance, it may well be another factor which will change the characteristic of the ward when patients come to it. The hospital administrator may want to know whether there are state match-

ing funds to pay for hospitalization in psychiatric units in general hospitals, such as there are in New York State. He will certainly want to know the provisions of his local Blue Cross contract. If the ward is to solve some sort of community problem, he will want to know whether the community itself is prepared to finance the cost of care for those patients who cannot afford it. Psychiatric patients, more than others, are unable to pay full cost for their own care.

3. What kind of unit should be set up for the population which is anticipated? As we have mentioned previously, the mere facts that psychiatric patients are usually ambulatory and active and that their activities are an essential part of their therapy mean that more space will be required. On the other hand, they do not need complicated food-serving mechanisms or oxygen supply units, and they should not put any considerable drain on the hospital laboratory service, pathology section, or X-ray department. Over and above this, it has been found possible to adequately treat many diagnostic groups with service provided only for parts of each day. The concept of the day hospital and the night hospital, sometimes using the same space, has developed from this knowledge.

Ewen Cameron (2), in his thoughtful article, challenges a good many of our ways of thinking about the psychiatric patient.

He points out, first, our tendency to assume that the needs of psychiatric patients are similar to the needs of patients with physical illnesses and that the structure of the treatment facilities set up for their care should be similar to those set up for the physically ill. Not only is it wasteful to provide all the services needed by the physically ill to this group of patients, but the provision of these services may actually make it more difficult to organize our basic treatment programs which should be social and psychotherapeutic. Cameron finds one reason for this trend toward similar facilities in the desire of the psychiatrist to achieve acceptance for himself and his discipline in the eyes of his medical colleagues. Let us admit, too, that until quite recently few psychiatrists and nurses had any definite ideas concerning what to do with the physically well, active patients that they had placed behind locked doors. In this vacuum of uncertainty, it was comforting for nurses to take temperatures and blood pressures, make a ritual of

medications, and to chart reams of irrelevant material. It was easy for doctors and nurses to fall into all sorts of meaningless patterns of activity. If they were to do something more constructive, not only did meaningless activity have to be eliminated in order to make more time for purposeful work, but the purposeful work had to be accepted as a right and proper thing to be doing.

Cameron's second point follows from this same sense of uncertainty. He feels that there was a sort of magical belief that adherence to the ritual of the general hospital would give the same kind of speedy results for psychiatric patients which it provided for the physically ill.

His third point is that if the psychiatric hospital were similar to the general hospital, it would be more readily accepted by the patient and his relatives. Cameron feels that this point may have considerable validity. The author cannot wholly agree with this, since it rests on the doubtful assumption that patients and their relatives do not really want treatment for psychiatric illnesses. It is, of course, true that most state hospitals are extremely forbidding and frightening places. It is, however, equally true that if we were to follow McKeown's suggestions, the psychiatric service could be the most open and least threatening part of the general hospital.

It is further true that the family of the patient wants to arrange treatment without having to accept the fact that the mental illness is a reality. This desire of the family is best accomplished by part-time hospitalization.

Cameron's remark that we should stop thinking of psychiatric units in terms of numbers of beds and start thinking of the use of space is an important point. Not only must adequate and appropriate space be provided within the hospital, but the relationship with other facilities should be explored before a psychiatric ward is planned. In no other group of illnesses is it so important to have outside space, a park, a picnic area, and a sports field available. The hospital's relationship with good transportation facilities, museums, and community recreational facilities should be thoroughly explored; and, if these are unfavorable, serious consideration should be given to the hospital having its own bus for its psychiatric patients.

Another important point raised in Cameron's article is the fact that psychiatric patients go to the hospital not to get well, but to

prepare to get well. Realization of this has led increasingly to the provision of aftercare services for the patient after he leaves the hospital. These services provide supervision for medication, counseling to patients and relatives, and an attempt to re-establish the patient in his social and occupational life. Successful readjustment in these areas is necessary if recovery from illness is not just a transitory phenomenon. However, we have to recognize that many who become mentally ill, particularly with schizophrenia, have a lifetime history of poor adjustment to work and society. Thus, the need is not for rehabilitation, but for habilitation. This is a formidable task, but one which the recent efforts in the field have demonstrated can be accomplished. A hospital which has or is planning a psychiatric ward should ask itself if it can ethically neglect to provide such a service.

Of course, as Cameron points out, some of the difficulty in returning to the community is eliminated if one never really leaves the community. A person who continues to live with his family during hospitalization will readjust to them gradually as he changes and will thus not be faced with a large and sudden readjustment problem when hospitalization is over. This will, of course, do nothing to handle the problems inherent in the person and his family before he came to the hospital and which may not be altered by the hospitalization. Apropos of patients' families, some have emphasized that the family should not visit during the early period of hospitalization. This idea, happily, is now dying a very rapid death, and any hospital designing a psychiatric unit should make arrangements in its plans for convenient and easy visiting and plenty of parking space. Particularly should parking space be emphasized for day patients, since many of them will drive their own cars.

Dr. Saslow (7) describes a still newer form of organization. His is a masterly plan for making the maximum use of a relatively limited amount of space. When the author visited his hospital, the ward could supply sleeping accommodations for twenty-nine persons, but was currently treating forty-five. Their attendance varied anywhere from twenty-four hours a day, seven days a week, to a half day a week. One of the most amazing things about this is the flexible system of the charges which they have worked out so that each patient pays for the ward time which he is using.

To recapitulate, it would be folly, in the light of these developments, to think any longer of a psychiatric service for patients who are either in the hospital or out of the hospital, and hospitals considering the addition of psychiatric wards should plan with such flexibility in mind.

4. What are the kinds and numbers of staff which will be required to run such a unit? Staff are more important in a psychiatric unit than in any other section of the hospital. It is in his interaction with the staff of the unit that a patient gets well. All persons on a psychiatric unit should be highly skilled in using themselves and their own personalities as therapeutic instruments. This is not an instinctive skill; it is something that must be learned, and usually it must be learned in inpatient conferences with the psychiatric staff of the ward. Even after it is learned, there is a continuing need for advice, consultation, and continual over-all organization of the program. This cannot possibly be achieved by having only a staff who use the hospital as a facility, as is usually done on most other hospital services. Like the laboratory services and the X-ray service, skilled doctors will have to be hired by the hospital to fill a coordinating and consultative role. It will be their duty to create the therapeutic environment which is the core of all other psychiatric treatments. In the absence of such persons, it is highly likely that the ward will be serving the purposes of a prison or of a high-class boarding house. Thus, if the treatments are mainly somatic and patients need restraint and custody between their treatments, the ward will serve the functions of a prison. If the patients are being treated mainly by psychotherapy, it is highly probable that, except for the convenience of a physician, most could be living somewhere else than in a hospital. Since the milieu is such an important part of therapy, relatively high staffing ratios will be required, and the staff on the psychiatric wards should remain with these wards and not be moved about from day to day from one service to another. This is not to say that key people from the psychiatric nursing service might not be used to introduce some of their nursing techniques on other wards. We are beginning to have convincing demonstrations that the application of certain nursing techniques which have been most highly developed among nurses working on psychiatric services are effective in preventing the many psychological complications which accompany hospital-

ization for physical illness. These complications cause inevitable increases in hospital stay of psychiatrically normal patients on surgical and medical wards. Our own unit has been doing research in this area, and we are quite convinced of the proven usefulness of some of these ideas. The Yale School of Nursing has been conducting studies in this area (8).

Since the author has been continually emphasizing the importance of the therapeutic use of the environment, sometimes called "milieu therapy," this often not too well understood concept should be further clarified (4). It has become commonplace to consider that the stresses and strains of the environment in which a person lives are important causes of the onset of a mental illness. In fact, one of the main rationales for hospitalization has been the intention to remove the patient from the noxious environment which brought on his illness. While there is a certain face validity to this view, it is remarkable that we have not given more attention and study to the constituent parts of a benign environment; and we have scarcely at all considered the possibility that if the environment has the ability to harm, it may also have an important role to play in cure.

A considerable portion of mental illness takes place in people who might be called undersocialized; that is, their abilities to deal with the ordinary stresses and strains of everyday life are less than the average person's. This lack of ability is often referred to as lack of ego strength, and certain illnesses, such as schizophrenia, are thought of primarily as being illnesses of ego-deficit and ego-collapse.

How can we build an ego which is more capable of solving problems? We believe that the answer is disarmingly simple in principle, although very complex in its application. In principle, ego strength or additional skills are acquired like all others through the practice in and use of inherent characteristics. If there are inherent weaknesses, even more practice is required. This is a simple prescription. However, when the person has become mentally ill, it is unlikely that he can begin with problems of the complexity that is usually found in ordinary environments. Many environments are filled with ambiguity. There are no clear-cut instructions as to what is expected of one, what facilities are available for problem solutions, what are the approved methods of

going about the solution, and what rewards and sanctions may be expected for success or failure in dealing with the problem. It should be obvious from this that the social environment of the mentally ill person will have to be much more carefully structured than we ordinarily expect from our own environments. For purposes of creating such an environment, we must consider a number of familiar categories. Ideas such as the authority structure, the allocation of roles, and the assignment of authority and responsibility are familiar concepts to hospital personnel. Within a good psychiatric ward, these have to be managed in such a way that there is power to make decisions on the ward about things which are important to the patient's life situation. If decisions cannot be made here, there will be ambiguity and lack of clarity. The patient will not be able to act, and if he does not act, he will not acquire new skills. The physical environment is important in this respect for two reasons. The first is that it communicates to the patient certain ideas about himself and what is expected of him in this particular setting; thus, obvious emphasis on security, such as bars, locked doors, and side rooms, inform a patient that he is considered incapable of controlling his own impulses and that, further, those in the environment are prepared to do this for him. Thus impulse control is not a problem for him and will not constitute an area where he is likely to learn while he is in the hospital. The second aspect of the environment is the facilities which it provides both for the nurses and the patients. In certain large hospitals, the environment is so badly planned and the administration so inadequately organized that the nurse and aide do little else but maintain the necessary inflow of supplies and keep the ward in a sanitary state. This obviously leaves them little or no time for working with patients to devise solutions to problems as they occur and to make attempts to solve them. It is important to remember here that it is often more difficult to assist the patient to work out his own solution to a problem than it is to do the particular task for him. However, one solution is therapeutic and the other is not.

Many of the skills which are necessary for the creation of a therapeutic environment are administrative skills. Much of the knowledge in this area has come from industrial sociology and theories of management. Thus in the psychiatric ward, more than

in any other portion of the hospital, there would seem to be an opportunity for an interesting collaboration between the psychiatrist and the hospital administrator. Such a collaboration would almost undoubtedly produce a better psychiatric ward and, at the same time, make the administrator more sensitive to the needs of all patients in the hospital. It is, in the long run, the patients who are the final concern of all of us.

REFERENCES

1. "Action for Mental Health," Final Report of the Joint Commission on Mental Illness and Health, New York, Basic Books, Inc., 1961.

2. CAMERON, EWEN, "The Day Hospital," in "The Practice of Psychiatry in General Hospitals," Bennett, A. E., et al., Berkeley, University of California Press, 1956.

3. COHEN, N. A. and HALDANE, F. P., "Inpatient Psychiatry in General Hospitals," Lancet, Vol. 1, pp. 1113-1114, 1962.

4. CUMMING, JOHN and CUMMING, ELAINE, "Ego and Milieu," New York, Atherton Press, 1962.

5. FORSTENZER, HYMAN, "Problems in Relating Community Programs to State Hospitals," American Journal of Public Health, Vol. 51, pp. 1152-1157, 1961.

6. MC KEOWN, THOMAS, "A Balanced Hospital Community," Hospitals, Vol. 33, pp. 40-44, 1959.

7. SASLOW, G. and MATARAZZO, J. D., "A Psychiatric Service in a General Hospital. A Setting for Social Learning," Mental Hospitals, Vol. 13, pp. 217-226, 1962.

8. "Summary of Research Carried out at Yale School of Nursing," mimeographed, obtainable from the Office of the Dean of Nursing.

THE EXISTENTIAL ATTITUDE AND THE THERAPEUTIC COMMUNITY

SHERMAN E. NELSON, PH.D.,* *Chief, Psychology Department*
Fort Logan Mental Health Center, Denver, Colorado

INTRODUCTION

Since World War II there has been an increasing awareness of a way of thought or philosophical attitude called "existentialism." This attitude has had influences on philosophy, religion, literature, art, and somewhat more recently on psychiatry and psychology. The author feels that some of the existential concepts have considerable value for the understanding and treatment of the mentally ill and, particularly, for the therapeutic community. A description of the particular therapeutic community where the author has made most of his observations, the Fort Logan Mental Health Center, is provided elsewhere (2). At first glance it may seem difficult, if not impossible, to discuss existential psychiatric or psychological concepts without an extensive excursion into the philosophy. It is an extremely wide-ranging, varied, and complex way of thought, and a thorough and comprehensive coverage of existentialism is a major endeavor in itself. It is, however, possible to review the particular existential concepts which apply to personality and to psychotherapy and in this way also get some "feel" for the whole philosophical attitude. Therefore only the briefest of background expositions of the philosophy will be given, and this will be followed by its applications for treatment.

THE EXISTENTIAL ATTITUDE

One of the major features about existentialism which has confused many people who have attempted to study and understand it

---

*Box 188, Fort Logan, Colorado.

Journal of the Fort Logan Mental Health Center, Vol. 1, pp. 71-85.

is that it is not, in the strict sense of the term, a school of philosophy, a dogma, or a cult. It is better regarded as a way of thought or a generalized attitude which can, and does, crosscut many different types of philosophy and many varied approaches to life. The popular and superficial view of existentialism is that it is a gloomy, pessimistic, intellectualized, and somewhat beatnik movement, adhered to largely by a group of highly self-conscious Frenchmen who sit around in cafes in Paris and impress each other with weighty and depressive observations about the nature of man and his future. This is, at best, only one branch or offshoot of the existential attitude, as exemplified in the writings of such people as Jean-Paul Sartre and Albert Camus. Actually, the existential attitude has been with man for many thousands of years, and traces of it can be seen in man's thought from the dawn of recorded philosophical speculations. The first thinker and writer to bring many of the existential concepts and ideas into focus was the Danish clergyman of the first half of the nineteenth century, Soren Kierkegaard. Since his time, many thinkers, artists, philosophers, writers, and theologians have been regarded as existential in their approach to life, or at least highly influenced by the existential movement. In addition to the modern French literary figures, Sartre and Camus, existentialism has been represented by philosophers such as Nietzsche and Unamuno, theologians like Paul Tillich and Martin Buber, the writers Kafka and Dostoevsky, social theorists such as Ortega y Gasset and David Riesman, and many noted and influential artists. The issue of utter pessimism, which is thought by many to characterize existentialism, actually applies only to some of its adherents. While some existentialists take a very pessimistic attitude, others arrive at a very optimistic outlook for man, his goals, and the meaning of his existence. Existentialism also crosscuts questions of religious belief or nonbelief. Sartre is an out-and-out atheist, while Tillich, a Christian theologian, and Buber, a Jewish theologian, find their faith reaffirmed through the adoption of an existential attitude.

The existential attitude is primarily concerned with the question of man's being or existence, as opposed to his essence, the major concern of philosophers in the past. Existentialists ask the question: "What keeps man from fully realizing his being or existing in the most meaningful way? What keeps man from full self-

awareness?" They feel that a lack of full self-awareness is the result of man's increasing estrangement from himself and from his world, and they give the following reasons for this estrangement:

1. Man has become increasingly detached from himself due to an overpreoccupation with the scientific and the rational. The more man studies himself as an object, the more he tends to distance himself from his real feelings and his real being. The existentialists speak of this as the subject-object dichotomy, and feel that the more man as the subject or detached observer has studied others as removed objects, the more he has tended to lose awareness of himself and of others. They point out that science has in no way really made man happier with himself, nor has science in any way made man's existence more meaningful for him.

2. Man has lost his true awareness of himself and of his existence through an increasing trend toward conformity in the economic, governmental, and social spheres. He has come to rely more on society and on commercial and governmental agencies for security and for the making of vital decisions concerning his life. In so doing, the existentialists feel that man loses or forfeits his true being. Two thinkers who have pointed out this trend most vividly have been Riesman, the author of *The Lonely Crowd* (6), and Ortega y Gasset in his treatise, *The Revolt of the Masses* (5). Certainly an indication closer to home of man's concern with losing himself in the crowd and in social conformity can be seen in the threat that various therapeutic community staff members voice from time to time that their treatment programs may become too oriented toward unquestioned group pressures as a major form of treatment.

3. Most existentialists, religious or nonreligious, feel that conventional religion throughout the centuries has largely failed man. Religion may function as a source of easy security, as is seen in the platitudes and social conformity of much of organized religion today. Too often it in no way helps or forces man to really face himself. Man takes refuge in religious dogma and in so doing sacrifices his true awareness of himself, according to much of existential thought.

CONCEPTS FOR PERSONALITY AND PSYCHOTHERAPY

The application of the existential attitude to personality, psychopathology, and psychotherapy began in Europe in the years after World War II. Its first exponents were men who had previously been orthodox psychoanalysts. Leaders in the movement were Frankel, Binswanger, and von Gebsattell. These men termed their methods of treatment "Logotherapy" or "Daseinpsychology." The leading American in the existential movement as applied to mental illness and its treatment is Rollo May (4), who has disseminated the works of the European existential psychological thinkers in the United States and has made a thorough examination of potential values for treatment. Besides May, other prominent theorists who are regarded as either existential or influenced by the existential attitude are Carl Rogers, many of the followers of Alfred Adler, Gordon Allport, Erich Fromm, and O. Hobart Mowrer. These men all have as their aim the understanding of what is termed "the patient-in-his-world." The goal is to achieve a full being-in-the-world for the individual and to help the patient to realize his maximum potential. Those who look for a characteristic and uniform technique or set of techniques from existential psychiatry or psychology will be disappointed. The existential thinkers in this area prefer to think of the value of existentialism as lying in the providing of an attitude or over-all approach to treatment, which can be used with many different types of techniques.

Self-Actualization, Self-Realization, Self-Emergence, or Self-Potentializing

The existentialists feel that man is always in a state of becoming. Man is not static or fixed into a given mold. Here we can see the greatest affinity of such men as Carl Rogers, Gordon Allport, and Alfred Adler with the existential attitude. The feeling is that man's greatest tragedy is not to fully realize his potentials, whether this lack of full realization results from social overconformity, too strict adherence to one dogma, or from mental illness. Man is to be evaluated not in terms of what he was, but from the standpoint of what he is and what he is becoming. Man is what he is striving for.

Certainly much of the therapeutic community approach consists in looking at the patient in terms of a greater realization of potential, whenever possible, and in deemphasizing the view of the patient as an entirely fixed entity who can do no better and is worthy only of being patched up. Many of the treatment approaches aim at the maximum achievement that each patient is capable of attaining, and the idea of pure support or care has never been the only principle in most therapeutic community programs. The existential thinkers feel that too many other schools or systems of treatment have tended to regard man as a relatively unchanging entity who can at best, when mentally ill, only be eventually restored to his former integration or equilibrium.

Antideterminism and Antifatalism

The existential emphasis is on man's freedom and man's free will. The really vital being of a person is found in what he *chooses* to be. It is felt that many religious philosophies have robbed man of this capacity and have promoted a kind of fatalistic approach to life in which man feels that his individual actions and decisions have no bearing on his existence. Science, on the other hand, with its deterministic philosophy has promoted much of the same thing in its emphasis on the theory that every action is ultimately predictable and that man, like all other animals, is nothing more than a machine receiving stimuli and acting on them.

The existential thinkers feel that the Freudians overemphasize the role of the unconscious and its influence on motivation. They contend that orthodox psychoanalysis and the systems of thought that it has engendered have imprisoned man in a deterministic framework, made up of a struggling ego largely at the mercy of the inner drives or id, and of the internalized dictates of society as represented by the superego. They point out that Harry Stack Sullivan's interpersonal theory, based on the principle that "man does not exist without society," has likewise bound up man in a social framework. Man is considered by the existentialists to be very strongly influenced by the society in which he lives, but also to be something else. He is still a unique individual. On the other hand, the existentialists believe that the behavioristic psychologists, as presently represented by Skinner, consider man

primarily as a bundle of reflexes, nerve endings, and synaptic connections. The behaviorists, in the existential view, tend to neglect the totality of man and the potentials of which he is capable. In interesting contrast to some existential thinkers in other fields who arrive at a very pessimistic and hopeless view of man, the existential psychiatrists and psychologists tend toward a highly optimistic orientation. They feel that the Freudian viewpoint has often promoted undue gloom as to man's capabilities and that other schools of personality and psychopathology have either shared this gloom or have neglected to look at man in the light of the high goals he is capable of achieving.

Responsibility

Man has the ultimate responsibility to fully experience or realize himself. He has the responsibility to achieve his being-in-the-world to his maximum extent. Much of this responsibility depends on the freedom and the responsibility man has to make his own choices. The existentialists would not exclude neurotics, psychotics, or character disorders from this ultimate responsibility. They would perhaps excuse mentally deficient children and brain injured people on the theory that because of their handicaps, these individuals are not fully human.

There are many implications in this concept for the therapeutic community treatment approach. Workers in the community like to see their programs not just as a means of support for patients through organized group and social modalities, but also as a means for getting patients to assume more responsibility for themselves and for each other. This attitude is certainly reflected in the many forms of patient government and in the many patient committees. It is also reflected in the staff's sharing of some decisions and planning with the patients, and in the frequently voiced attitude, "You do it," or "You work on it and come up with a better idea." On the other hand, concern is frequently expressed over the problem of the loss of the individual in the group. Too much emphasis can be placed on group pressures to the detriment of the individual, and here the existential attitude with its never-ceasing emphasis on the individual's responsibility for himself may be of help. It can help the therapeutic community worker focus on the fact that

individuals are being treated despite the heavy reliance on group methods, and it may keep staff members from tending to think of their patients as only interchangeable units in the group or mass. The security of the group experience and the general therapeutic community atmosphere may not always prepare the patient for outer living where the comforting modalities of the community are not available. A continual emphasis on the patient's responsibility as an individual for himself, for his group, for his family, and for the total treatment program should always be a major element in the therapeutic community treatment philosophy.

A-Historical. Present and Future Oriented

The past is considered to have its meaning only in terms of the present and the future toward which the person is always going. Our goals and plans for the future determine what we will remember of our past and what we will do about these memories. This is in considerable contrast to the more orthodox Freudian point of view, which is that the past is the major determinent of the adjustments and maladjustments of the present and that the future is largely what the individual brings to it from the past. It is felt that one of the major handicaps of many maladjusted and mentally ill people is their fear of facing the future and their clinging to past methods of resolving problems, no matter how inadequate they may be. "The neurotic is a prisoner of his past." The exaltation of the past and the using of the past as an excuse and rationalization for the inadequacies of one's present is seen in its most extreme form in the "professional psychotherapy or mental hospital patient." Certainly many mental patients justify their behavior mainly in terms of their emotionally traumatized and deprived childhoods. Alfred Adler was one of the first to emphasize man's future goal-directed nature, and, in this, his theory has affinities with existential thinking. This accounts for the liking many present-day Adlerians feel for existential concepts. There is the feeling that orthodox analysis has long hobbled much of psychotherapy, personality, and psychopathology by its overemphasis on the past.

Much of the orientation in the therapeutic community is a-historical. Major importance is placed on the patient's present conflicts as expressed in daily group living situations. Staff

members, harking back to their traditional training, often feel a certain comfort in realizing that a given patient's dependency may have stemmed from an overprotective or, on the other hand, a depriving mother, but by and large the primary emphasis is on the modification of behavior as it appears in the living present. Interpretations along the lines of, "You really hated your mother," or "Your problems stem from your resentment of your father's domination," are occasionally made, but are rather rare. On the other hand, perhaps there is too much of a tendency at times in the therapeutic community to neglect the future orientation with the patient and to overemphasize the present in too much of a day-to-day way. A great deal more emphasis could and perhaps should be placed on the tentative setting up of goals with patients in the early days of admission, even though these often need to be modified. The question, "Where is this patient heading?" is one that staff members should more frequently ask themselves, the patient, and his fellow patients. The amassing of large amounts of detailed past information on patients has often been unduly time-consuming and has taken treatment time away from the present and future orientations. This is not to say that histories are undesirable, but it does point out that very lengthy and time-consuming ones may be largely unnecessary, except for training and research purposes.

Anticatagorical = Anticompartmentalizing = Antifragmentizing

A major existential principle is that man is not just a collection of faculties, traits, drives, reflexes, instincts, defense mechanisms, or roles all subsumed under a diagnostic label. The tendency to see a man as a collection of labeled parts has too often contributed to seeing man solely as an object to be studied. This has detached the observer or therapist from the patient. A person must always be regarded as an existing totality, and, while for purposes of study he may be broken up into parts or categories, one should never forget that he lives and functions as a total being-in-the world.

In the therapeutic community, constant attempts are made to avoid categorization. It is fairly rare in discussing a patient, either with staff or with patient groups, that extensive use is made of labels, rubrics, or technical terminology. Staff try to continually see patients as total persons.

Crisis Oriented

Existential thought is geared to the crises of our time, which existentialists see as resulting primarily from man's estrangement from himself. Man no longer feels free to make a choice and must rely on others to do it for him, or he remains in a state of agonized indecision. Existential psychologists and psychiatrists see the mentally ill as individuals in states of crisis which result largely from the necessity to make choices which they feel unable to make. In existential thinking, one of the greatest crises occurs when a person is faced with the necessity to make greater use of the potentials of which he is capable. Some individuals face this courageously and achieve greater self-realization, others look to their fellow man for help in living and abdicate their responsibility to realize their full potential, and others remain in a state of indecision.

In the therapeutic community, some lip service is paid to the importance of immediate conditions precipitating the patient's admission, or what might be called the crisis requiring hospitalization. This is described in such terms as "external precipitating stress" on psychiatric examinations. Unfortunately, these factors may not be examined extensively enough, and some patients are regarded as so chronic that the particular immediate conditions or crises which bring about their acute illness are not considered to be of prime importance. More attention to these crises might make it possible to plan treatment and disposition more effectively. Another crisis which the patient faces which equals and sometimes surpasses the intensity of the crisis of admission is the one involved with reduction of treatment or the imminence of discharge. Because some patients make far less outward fuss about this than others, the assumption is sometimes made that no crisis exists. However, staff are occasionally rudely reminded that it does, in the relapse of the patient or in desperate requests for continuation or for greater intensification of treatment. The patient should be seen as a person who is in a state of crisis on admission, during the stay, and on separation. More help should be given in getting the patient to face the crises resulting from the need to make choices which involve the greater use of his potentials to lead a healthier and better adjusted life.

Non-Being

To the existentialists, there are three major threats to being: namely, death, conformity, and anxiety and hostility.

Death is, of course, the ultimate in non-being. The meaning of death to man in life occupies much of existential thought. Existentialists hold that for man to fully grasp what it means to exist, one needs to fully face and courageously grasp the fact that at any instant he might cease to exist, and that eventually he inevitably will not. In fully confronting the fact of death, one's existence takes on vitality and meaning. It is no accident that some of the foremost existentialists after World War II were Frenchmen who had been most active under the German Occupation. The daily threat and acute possibility of death was felt to have brought an increased awareness of the values of one's own being and existence.

The second major threat to being is overconformity, which is considered to be a misguided escape for the individual from the threat of non-being, an escape which really eventuates in sacrificing his powers and real potentials and diminishing his true being or existence. Erich Fromm has written a very telling account of man's flight into security at the cost of full self-realization in his book *Escape from Freedom* (3). It is Fromm's thesis that man has too often fled from his true self by taking refuge in the authority of an individual, a group, or an institution.

The third major threat to being is found in anxiety and hostility. These feelings often strike at the central core of our being, in that they threaten our self-esteem and self-values. Both of these stem from the need, the opportunity, and the challenge to fulfill one's potential, and one's feeling of inadequacy to do so. There is seen much of the existential rationale for the tension felt by patients when facing the possibility of better adjustment, jobs, reductions in treatment, or leaving the hospital. Not fulfilling one's potentials, or denying them, results in guilt. One does not just feel guilty, one *is* guilty. O. Hobart Mowrer, a psychologist and treatment theorist, believes that much of psychotherapy should be based on this assumption. He feels that too often our approach has been to point out the unreality of the patient's guilt when a certain measure of real guilt exists, and that our best approach

should be to help the patient recognize, express, work through, and even atone for the guilt by constructive action. In more concrete terms, a patient's anguished recital of guilt-ridden acts of commission or omission is met by an acceptance on the therapist's part of a real basis for guilt, followed by efforts to help the patient make plans and take action to change behavior and attitudes which induce guilt. Suicide is regarded by many of the existential psychiatrists and psychologists as having something of a positive value. It is felt to be, at the very least, a choice that a person makes. They would feel, however, that the suicide of a mental patient is often based on false assumptions, misperceptions, and unrealistic thinking, and is a running away or a denial of one's real potentials for a productive and constructive life.

Commitment or Involvement

A person must be fully committed and involved in his life, and those helping him to improve his life must be fully committed and involved as well. A patient cannot receive insight or change until he makes a commitment to a course of action in terms of a decision or a choice to make a change. The existential therapist would feel that self-awareness and insight do not occur prior to major decisions in life, but only follow after. They feel that the therapist must be fully committed or involved with the patient to fully perceive the patient's crisis. He then helps the patient face it so that the patient can make the commitment or the choices necessary for modification in his adjustment. The patient does not grow or improve by explanations, but by experiences shared with the therapist. The neutral, detached therapist distances himself from the patient and cannot fully help the patient benefit from the treatment. The rationale for the more neutral or detached psychotherapist came originally from psychoanalysis, and was based on the premise that the therapist had to avoid the distortions and misperceptions which presumably would result from overcloseness or involvement with the patient. Existential thinkers feel that the therapist can afford a great deal more involvement in terms of frankness and openness with the patient, if the therapist knows himself well and has a clear idea of what he is doing and why he is doing it.

In the therapeutic community, commitment, or involvement in the patient's treatment, is a major emphasis. In all phases of daily living and in the patient's treatment a high degree of staff involvement is encouraged. Frankness, openness, and spontaneity are highly prized approaches to patients, and attitudes of neutrality, detachment, and distance are definitely discouraged. This stems, of course, from the feeling that the therapeutic community requires involvement rather than detachment. However, our existential colleagues would argue that the therapeutic community worker is striving for "living with" or "being with" the patient in the treatment world to the fullest extent.

Denial or Deemphasis of the Unconscious

Many, although not all, existential theorists and therapists feel that the unconscious is an archaic concept which has done all too much to hamper and hinder a more realistic and vivid approach to man and to treatment. They argue that the concept of the unconscious has too often provided a rationalization, an escape, a denial, or an excuse for not facing one's own problems. Much of what we have tended to regard as due to unconscious motivation in patients is subject to a far greater measure of conscious volition than we have heretofore assumed. Some existentialists are willing to retain the term "unconscious" as an adjective for acts or attitudes which have not been brought into focus for a reflecting consciousness. However, much of their thinking is based on the assumption that the unconscious is a self-deception which can be overcome when true self-realization is achieved.

In the therapeutic community there is a great deal of pointing up of behavior and feelings to the patients, some of whom have been very disturbed people. This sometimes results in a very gratifying modification of behavior on the patient's part. Even in cases where no immediate change occurs, it is rare that this approach makes the patient worse. The staff members in the therapeutic community have come to realize that when patients express themselves in terms like "It's my sickness," or "It's out of my control," or "I don't know why I act that way," they often are finding handy rationalizations and escapes from the direct confrontation and realization of their problems, from their potential to control their behavior, and from their capacity to change.

DISCUSSION

The author believes that the existential attitude in psychology and psychiatry has significant applications for treatment within a therapeutic community. As a result of observations at the Fort Logan Mental Health Center, significant value is seen in the following concepts: An optimistic view of the individual's potential, viewing treatment as an attempt to help the patient realize his maximum potential rather than just as a technique for patching up or restoration of the status quo, the individual's freedom to choose and to some degree decide his own future, the emphasis on the individual's responsibility to improve, the deemphasis on the historical point of view and the great emphasis on the present and future, the attitude against compartmentalizing or sectioning the the personality of the individual, and the pointing up of the need for maximum involvement with the patient on the part of those treating him.

The existential attitude, however, is not immune from reasonable criticism by those working in the field. Some feel that the existential denial, if it could be called that, of the concept of the unconscious is simply a denial without stating a clear reason why the concept is denied. They feel that the unconscious is still an extremely important factor in behavior and that it cannot be sloughed off simply by saying it is irrelevant. Others feel that the "new" ideas which have come from existentialism have been arrived at over the years by other schools of psychology and psychiatry quite independently of the existential movement. The point could be made that many of the existential concepts have been stated by other practitioners, particularly the ego theorists such as Hartman and his followers. Ego psychology certainly has brought about an increasing emphasis on the living present and less emphasis on the id, superego, and the unconscious. Along with the emphasis of the ego psychologists and psychiatrists on the present have come other approaches somewhat similar to existentialism, such as increasing responsibility on the part of the patient and a swinging away from the extreme emphasis on the genetic or historical view of the individual. However, the existentialists would argue that while many good things have come into the areas of psychology and psychiatry through the ego psychology movement, this school

is still far too mechanistic for their taste and ignores much of what contributes to each individual's uniqueness. Certainly the emphasis on the social aspects of man's being-in-the-world has been brought to our attention by the Neo-Freudians and particularly by Harry Stack Sullivan and Alfred Adler. Self-actualization, which is so much a cornerstone of the existential attitude, was pointed up as an important dynamic by Carl Rogers and Gordon Allport long before there was a movement with the name of existential psychology or psychiatry. These qualifications and criticisms do not, however, bother the existentialists to any great extent. They have a rather clever and possibly even insidious answer to these points, and it is simply that whatever school one may believe one belongs to, or whatever one's theoretical identification in the field, if one is thinking along the various lines that have been described earlier, one is basically an existentialist. One of the most serious criticisms that has been leveled against the existential attitude in treatment is that it can easily become a school "in itself," with its own dogma, terminology, and ingroup feeling. There certainly may be some truth in this, in that existentialists tend to be somewhat evangelistic and often want to carry their point of view to others to the point of conversion. There is also a danger in the existential attitude of becoming too intellectualized and thereby losing the very self-awareness, self-realization, or full potential of one's existence that one was searching for in the first place. Some skeptics, among them existential thinkers, have pointed out that the only true existentialist is the simple, uncomplicated man who is fully living in his existence. They feel that the thinker, the student, and the analyzer, whether he is regarded as existential or not, may lose the very thing he is searching for. Can an intellectual, learned person be truly existential in attitude? One encouraging answer to this difficult question is that if he searches honestly he may be regarded as such.

REFERENCES

1. BARRETT, W., "Irrational Man: A Study in Existential Philosophy," New York, Doubleday and Co., Inc., 1958.

2. BONN, ETHEL M. and KRAFT, ALAN, M., "The Fort Logan Mental Health Center: Genesis and Development," Journal of the Fort Logan Mental Health Center, Vol. 1, pp. 17-27, 1963.

3. FROMM, E., "Escape From Freedom," New York, Holt, Rinehart & Winston, 1961.

4. MAY, R., "Existence: A New Dimension in Psychology and Psychiatry," New York, Basic Books, Inc., 1958.

5. ORTEGA y GASSET, J., "Revolt of the Masses," New York, W. W. Norton Co., 1932.

6. RIESMAN, D., "The Lonely Crowd," New Haven, Yale University Press, 1950.

DEFINING THE ROLE OF THE PSYCHIATRIC NURSE

HELEN HUBER, R.N., M.S.N.,* *Chief, Nursing Department*
Fort Logan Mental Health Center, Denver, Colorado

INTRODUCTION

What is a psychiatric nurse? What is her role? What skills and theoretical background should she possess? How can she function most effectively and in what settings? The nursing profession has been pondering these questions for some years.

A series of papers published in the June 1962 issue of the *American Journal of Nursing* (3, 6, 9) demonstrated the various viewpoints held by some leaders in psychiatric nursing. These viewpoints ranged along a continuum from the nurse as an individual psychotherapist at one extreme to the nurse as a manipulator of the patients' environment at the other. The discussion has gone on heatedly yet leisurely, as if the ultimate decisions had implications for none but nurses and as if time were not crucial.

The prepared professional is, in my opinion, best able to define what services can be offered by the profession at a given time. It is important for the professional to be alert to the needs of the public, for whose service a profession exists, and to determine what steps the profession must take to meet those needs more effectively. Lambertson (5), in defending nursing's right to self-determination of role, says:

> It is the prerogative of the practitioners of the profession to define this hard core of professional service. Related groups are concerned, but the final determination of the professional mission is the right and responsibility of the practitioner.

Nursing frequently points out its important role in the treatment of the mentally ill. Yet our failure to come to some beginning agreement on the nurse's role in the psychiatric field, after almost ten years of study and discussion, suggests greater concern for the

*Box 188, Fort Logan, Colorado.

Journal of the Fort Logan Mental Health Center, Vol. 1, pp. 87-101.

nurses' interests than for the patients' needs. Our temporizing and intramural debates must give way to working cooperatively with the other health disciplines to find more effective means of treating the mentally ill. Custodialism is intolerable.

The public, frightened by its growing awareness of the incidence of mental illness, demands action. The public is angry and confused by the barrage of conflicting ideas from professionals as to what is sound treatment; who is competent to treat patients; what length of training program is necessary to produce such therapists; how long it will take the professions to provide the number of well-trained personnel needed to meet the demand.

Despite a requirement that a basic psychiatric experience be part of every nursing student's preparation and a conviction that graduates of accredited basic programs are prepared to function in beginning staff-level positions, nursing has failed to develop such a "first-level" position in psychiatry. Relatively few of the total number of registered nurses in the United States list psychiatry as their clinical area; only 5% work in the psychiatric field (including instructors, consultants, etc.). Less than 1% work in public mental hospitals. Therefore, less than 1% of all nurses in the United States are involved in the treatment of almost half of the patients.

In this paper I will discuss some of the factors contributing to this failure of nursing to define a significant role in the treatment of the mentally ill. I will also describe the steps taken at the Fort Logan Mental Health Center to establish a role for the staff nurse, the nurse's responses, problems encountered, and implications for nursing in general.

CONCEPT OF ROLE AND RELATED IDEAS

For the purposes of this paper, the term "role" is used to designate "the organized actions of a person coordinate with a given position." (11) A further refining of the term "role" as "a patterned sequence of learned actions or deeds performed by a person in an interaction situation" (11) is useful. "Role expectation" is understood to mean the behavior which people in a given society expect of a member occupying a certain position in that social system (1). "Role definition" refers to the process through

which the individual develops his own concept of the chosen role and his expectations of himself in carrying it out (1). The term "role expansion" denotes the broadening of the prescribed social role to include actions not previously assigned.

FACTORS CONTRIBUTING TO THE LACK OF DEFINITION OF A NURSING ROLE

1. Ambiguity Concerning Lines of Authority and Decision-Making in Nursing

I propose that much of the difficulty encountered in defining the role of the nurse lies in nursing's perception of itself as *an amorphous service which takes its form and direction from the expectations of others.* Such a perception of nursing is shared by other professions.

Some of the roots of this perception are identifiable. The majority of nurses in the United States have received their basic education in hospital schools of nursing. Until recent years, hospitals were organized to provide centralized, convenient services for their communities' physicians. Decisions about the ordering of the daily, routine affairs of the hospital were generally based on the wishes of the physicians or on the efficiency of hospital operation, rather than on the desires and the needs of the patients. Nursing students have been influenced by this, in spite of the attempts of nursing educators in such settings to focus on the needs of the patient. Mullane (7) suggests that the chronic nursing shortage will not be solved until nursing resolves its conflict over this question.

In relating sources of job dissatisfaction, nurses frequently mention the conflicting demands of a) the managerial and paperwork duties required by hospital administration; b) the doctor's emphasis on performance of technical duties to assist him in his diagnosis and treatment of the patients; c) the patient's need for support, assistance, and interest from the nurse; and d) the demands of the nursing department.

The nurse is faced with assigning priorities. She verbalizes belief in the teaching that the patient comes first. Nevertheless,

the patient is the least constant factor in the environment, and the nurse's needs for approval and job security are more directly influenced by the attitudes of the physician, the hospital administration, and the supervisors in the nursing department. Whatever choice she makes cannot be wholly satisfying to her.

2. The Nursing Profession's Failure to Interest Nurses in Employment in Public Mental Hospitals

Nurses frequently have rationalized the profession's failure to contribute to the psychiatric field on the basis of poor working conditions. They have complained about factors ranging from the presence of too many patients to permit therapeutic interaction to poor salaries. Nurses have also attributed their failure to move into this field to lack of support, assistance, and direction from psychiatrists. In my opinion, psychiatrists have needed colleagues who could use initiative in identifying and meeting patients' needs, not dependents whose every action had to be spelled out.

Such excuses dodge the issues. Nursing could have provided to the patients staff members who a) were interested enough in the patients' welfare to try to understand their communications; b) could provide healthy relationships and reality testing; and c) could support and assist the patients' efforts at relearning social skills.

3. Nurses' Reactions against Customarily Assigned Role in Large Mental Hospitals

Because nurses in large mental hospitals have been so scarce, their functions have been determined largely by minimum requirements for hospital accreditation. Nurses are utilized chiefly as supervisors, administrators, and instructors. Frequently, the medical-surgical unit is the only service in such a hospital where a nurse participates in the direct care of patients. In the supervisory role, the nurse is often responsible for a staggeringly large number of patients and personnel. As a result, the supervisor's efforts are directed toward keeping statistics such as patient census, staff attendance, transfers, linens and pills; making decisions about the handling of emergencies; and serving as a liaison

between administration and the nursing staff of the unit. Under such circumstances, the supervisor's awareness of the patient's situation and her supervision of personnel toward improving program and the level of staff functioning are of necessity minimal.

Some state hospitals have been utilizing nurses at the ward level. Since these nurses usually function as supervisory or educational resources for other ward personnel, their assignment to ward duties has produced little movement toward the definition of a therapeutic nursing role. On the other hand, budgets and staffing patterns in many such hospitals have kept the ratio of nursing personnel to patients at a custodial level, and thus have promoted chronicity of the patients' illnesses. Nurses, when faced with the overwhelming problems in a large state hospital, often have resolved their conflicts by a) leaving the field; b) continuing to struggle with the problem with but little sense of accomplishment; or c) giving in to the "system" and accepting the managerial, paper-pushing role described previously.

4. Negative Reactions of Nursing Students to Nursing's Role in Large State Hospitals

Large numbers of student nurses have received their basic orientation to psychiatric nursing in large state hospitals and have reacted negatively. Many senior students and young graduate nurses voice a strong interest in psychiatric nursing as presented by their instructors, but hasten to add, "I couldn't work in a state hospital, though." Thus, the large public hospital, which employs so few professional nurses, has further limited its chances of recruiting them by the professional image it presents and by the way it utilizes nurses' services.

5. The Designation of the Therapeutically Active Nurse as "Exceptional"

Until recently, the nurses working in private psychiatric hospitals were little involved in the task of defining a therapeutic role for themselves or for nonprofessional nursing personnel. Any nurse whose interest and skill led her to seek a more active role in patient-treatment programs was most often regarded by the

psychiatrists with whom she worked as the "exceptional" nurse. She was then allowed wider therapeutic range than others, rather than seen as an example of what nurses generally might be able to do if encouraged, supervised, and assisted in developing similar skills. This kind of isolation of function has tended to foster a belief on the parts of nurses and psychiatrists that the "exceptional" nurse is doing something that is not nursing--thus relieving other nurses of guilt feelings over their own lack of skill in this area and relieving the psychiatrists of similar feelings over "playing favorites."

6. The Nursing Profession's Failure to Take Responsible Action

As indicated in the introduction, the nursing profession has spent much time in discussing various approaches to and aspects of psychiatric nursing. In our drive for professionalism, we have spent much effort disputing what academic degrees are required before competency is established. A number of psychiatric nursing specialists feel we must vie with colleagues in the other social science disciplines for the roles of individual and group psychotherapists and family counselors. The nursing profession's agreement that clinical specialization should occur at the master's program level has tended to confuse the issue. The implication is that since nurses should have the role of therapists and preparation for this can be obtained only in the graduate programs, only nurses with master's degrees should work in psychiatric settings. Such a distortion deters many from entering the field.

These, then are factors which must be kept in mind when planning psychiatric nursing services. They color nurses' perception of this field of practice. They directly influence staff recruitment and selection, and determine the process of staff development and utilization.

THE NURSES' ROLE AT THE FORT LOGAN MENTAL HEALTH CENTER

Following the establishment of the center, the first director assembled a core staff, representing the various health and admin-

istrative professions, to develop the center's program. During the six-month period prior to the admission of the center's first patients in July of 1961, a subgroup of the core staff, which included several psychiatrists, a nurse, a psychologist, and a social worker, formed a planning group to delineate the broad aspects of each discipline's role. The general framework of the nurse's role is described below.

Recognition of the Nurse's Therapeutic Role

From the inception of the center, nurses were viewed by the planning group as being able to function in a much broader role than is usual. While this suggests an expansion of role, the planning group was simply giving formal recognition to the therapeutic value of the patients' daily living experiences in which nurses and technicians have long been participants. The work of Jones (4) has focused attention on the therapeutic potential of the patient's total hospital experiences.

Therapeutic and Antitherapeutic Potentials Re-examined

The studies reported by Greenblatt, et al. (2) and Stanton and Schwartz (12) demonstrated ways in which nursing personnel may manipulate the hospital environment to serve the patient therapeutically or antitherapeutically. The antitherapeutic manipulation was most frequently rooted in nurses' and technicians' a) ignorance of the therapeutic goals; b) ignorance of the relationship of their actions to these goals; and c) acting to meet their own needs in handling their feelings toward patients, co-workers, and administration at the expense of the patient.

It was the belief of the planning group that through careful selection, orientation, preservice and inservice education, and ongoing supervision of nursing personnel, nurses and technicians could be assisted to maximize their therapeutic potential and to minimize their antitherapeutic activities. A number of aspects of the nursing role conceptualized by the planning group correspond to several of the subroles described by Peplau (10): those of a) technician (administering medications, assisting with EST, etc.); b) manager (scheduling, assignments, etc.); c) teacher and

socializing agent. Since all the patient's hospital experiences were viewed as potentially therapeutic, the planning group saw the nurse functioning as a psychotherapeutic agent in all these areas of function, and not merely when she served as a group therapist or in a one-to-one relationship with a patient.

Special and Unique Roles

The planners singled out two aspects of the nurse's role for special emphasis: a) *assisting the patient with his task of re-socialization* and b) *manipulating the environment to increase its therapeutic potential for patients.* Round-the-clock participation in the patient's treatment was solely the responsibility of the nurses and technicians, while responsibility for the patient's physical health was shared with the psychiatrist.

Blurring, Expansion, and Delineation of Roles

The planning group saw all the disciplines on the team as sharing a common core of activities: planning patient care, milieu therapy, group therapy, progress evaluation, follow-up care of outpatients, community education, research, training, and record-keeping. In addition, each team member was seen as having certain areas of competence that derived from his particular professional training and experiences, and for which he would be responsible as a team member. (E.g., the nurse's tasks of administering medications, taking the patient's blood pressure, applying bandages, etc.) In order to utilize to the highest possible level each team member's potential, the planning group agreed that staff members should be encouraged to develop additional skills for which they showed aptitude and interest, whether such skills were ordinarily within the scope of the individual's role or not. This concept led to the use of the term "blurring of roles." For example, all team members, including nurses, were to function as therapists in the activities program.

It was the belief of the planning group that further role delineation should be an ongoing process in which team members would have opportunity to explore and define the dimensions of their roles that had usefulness to patients in this treatment setting.

DEVELOPMENTS IN NURSING ROLE DEFINITION WITH THE GROWTH OF THE PROGRAM

Analysis of Blurring

In the initial phase of the center's operation, staff members from all disciplines spent a good deal of time discussing the blurring of roles. The term "blurring" was used to signify a lack of clear-cut definition of the role of each team member in terms of his own discipline. It was generally held that such a lack of clear definition would promote the use of a given staff member on the basis of his ability to relate himself effectively to the patient. It was also felt that development of staff potential would be fostered if disciplinary barriers were minimized. A social worker might share the traditional functions of his role with other team members and, in turn, take on responsibilities usually assigned to another discipline. A nurse might obtain the patient's social history, while the social worker might admit a patient to the hospital.

In the light of subsequent discussions and events, the use of the term "blurring" probably signifies the relative ignorance each discipline had of another's potential and limitations. To this observer, it seems in retrospect that awareness of other disciplines' roles and potential lined itself up along the usual "pecking order" (i.e., a) psychiatrists, b) psychologists, c) social workers, d) nurses, e) technicians). That is to say, a given staff member was most aware of his own discipline's role and potential; he was aware, secondly, of the role and potential of those above him on the pecking order; and he was least aware of those below him on the scale. Conversely, members of each discipline seemed to hold fewer opinions about the limitations of skill or knowledge of those above them in the pecking order and more opinions about the limitations of those below them in the order.

For example, in considering the one-to-one relationship as a training experience for psychology and social work trainees, the question of its appropriateness in the Fort Logan setting arose. It became apparent that some psychiatrists, psychologists, and social workers were unaware that use of the one-to-one relationship with a patient was part of basic and graduate education in psychiatric nursing.

As our experience grew, it became evident that blurring actually involved an expansion of the customary role of each clinician. One discipline's expansion of role at a given moment usually meant that another discipline's customary role was shared or perhaps restricted. For example, as the psychologists and social workers on a team became active participants in the discussion of team-management problems and proposed solutions, the nurses and technicians shared their responsibility for solving such problems and gave up some of their power to control the patients' environment. The team leader expanded his role in acquiring administrative responsibilities for his team, but shared his role of decision-maker with fellow staff members. Retrospectively, it seems that staff members from the various disciplines regarded their roles as expanded when the new tasks a) were consistent with their previous concepts of their professional role; b) were valued by the staff members above them on the pecking order; or c) were in line with their criteria of what was good use of a professional's time.

Role Restriction and Task Realignment

A feeling of role restriction occurred when a task rating high on their value system was shared. Willingness to share less valued tasks was evident. On the other hand, being asked to assume some of the lower-value tasks was frequently regarded as "buck-passing."

On the basis of these experiences, one would suspect that the nurses' and technicians' roles might grow to improbable proportions as they reach out to incorporate more highly valued tasks and are called upon to share in the less valued tasks of other disciplines who are also expanding roles.

This kind of shifting of tasks has been the experience of the nursing group in the general hospital setting. As a result, new nursing subroles, which require less training, tend to spring up to absorb the less valued tasks which are abandoned by nurses. For example, as nurses inherited from the doctor the tasks of taking blood pressures, changing surgical dressings, and starting intravenous infusions, less of their time was available for performing such tasks as bathing and feeding patients. Hospitals

began to employ "auxiliary" nursing employees to do these tasks. Economics and nurse supply together partly explain why this solution was chosen by hospitals rather than that of increasing the number of professional nurses in their staffing patterns. But the question of why nurses chose to give up the tasks involving prolonged contact with patients rather than some of their managerial tasks remains.

Roles Defined in Terms of Tasks

The nurses in the early phases of the program were greatly occupied with developing skills in group and activities therapy, with learning to participate in the decision-making entailed in a team approach, and with their usual role of participant-observer in the daily living experiences of the patients. They demonstrated, along with members of other disciplines, a willingness to examine and question the validity of old concepts of psychiatric treatment and to explore new ones.

The work setting at Fort Logan is a much less structured one than most nurses had experienced. There are few situations for which action is determined by standing policy. Instead, the expectation is held that team members will decide such action on the basis of the needs of the patient at the time and in accordance with the concepts of therapeutic community.

An intensive learning experience for most of the nurses was that of examining their own participation with patients. It was necessary to understand the nature of this participation, to assess its therapeutic value, and to modify it when it was ineffective or antitherapeutic. Most nurses had experienced this kind of self-examination as students, but few expected it to continue after graduation.

The uneasiness occasioned by these learning experiences was expressed by the nurses in part through behavior similar to that which Norris (8) observed during the evolution of nursing roles in another treatment setting. The nurses and technicians asked for specific answers to handling problems in managing their units. For instance, there was considerable talk about the need for a hospital rule prohibiting staff from accepting gifts from patients at Christmastime. As the discussion developed, it was

evident that staff members would utilize a rule as an easy way out of a situation they wished to avoid, rather than for its learning potential for the patient. Nursing staff members frequently expressed anger at the lack of clearly defined structure and absence of guidelines--anger at the very freedom to act which attracted them to their positions in the first place.

This points up the function of rules and regulations in traditional settings, not only as the means of insuring minimum standards of care and performance, promoting efficient, smooth-running hospital operation, but also as tacit sources of reward and punishment. Thus, in functioning within the bounds of rules and regulations of his organization, the worker is confident of the acceptance and approval of the authorities. At the Fort Logan Mental Health Center, lacking the detailed instructions for action and guarantees of approval, nursing personnel sought rules from their department for dealing with the less pleasant situations. They also reached out for tasks that obviously ranked high on the staff value scales, such as group therapy and taking social histories.

It is my feeling that this focus on rules and valued tasks related to the nurse's longstanding conflict over whom to please--the patient, the physician, hospital administration, the nursing profession, or herself. In asking for rules and in selecting tasks valued by the higher-status professions, the nurse seeks greater security and approval for her actions. By so doing, however, she delays the development of a role which stands on its own merits because it meets the patient's need and utilizes skills which only the nurse has developed.

ROLE CONCEPTUALIZATION VERSUS TASK DELINEATION

Nursing has tended to define itself in terms of performed tasks rather than in terms of services. This focus on tasks rather than on the concepts underlying the nursing role limits the freedom of nurses in handling new situations and also fosters rigidity. We have hardly begun to identify such concepts. Unless we do so, however, nursing cannot hope to extricate itself from its present chaotic state.

The tendency of the higher-status disciplines to displace their less valued tasks onto nursing and of hospital administration to expect nursing to extend its scope to include non-nursing, hospital-management tasks, reinforces nursing's poor concept of its appropriate tasks and of their importance to the therapeutic program. Nursing personnel frequently have expressed their anger about this practice and the other disciplines' lack of awareness of therapeutic opportunities nursing personnel have in participating in the patients' daily living experiences. Nevertheless, when invited by the Nursing Department to participate in a study of the nurse's role, many nurses signified a willingness that their functions be defined by other disciplines or that they be gradually evolved. Others implied that the task of role definition was a "busy-work" project of the nursing department designed to take time away from important team activities. Some of the very young and inexperienced staff members were, of necessity, involved in developing basic skills in communicating and in interpersonal relationships. Moreover, some of those who had developed such skills during their basic nursing education tended to confuse *the skills* required by the role with *the role* itself. They had to learn that interpersonal relationships and communications are not all of psychiatric nursing.

VALUES OF THE NONDELINEATED ROLE

Since the conceptualization of a role and delineation of its functions would appear to have many advantages, such as increasing security, providing guidelines for decision-making, etc., it is useful to speculate on the advantages inherent in a nondelineated role. On the basis of the previously described factors, I propose that the reasons nurses perpetuate the nondelineated role might be that: a) They seek to avoid the conflict over whom to please by avoiding definition of their role and the related tasks; b) They perceive themselves as having greater freedom to act in response to a given set of circumstances, which would seem to imply that role definition is perceived as role restriction; c) They feel less responsibility for initiating necessary action; d) Lacking the guidelines of a specified role, they feel less guilty for acting

impulsively or arbitrarily; e) Lack of a defined role might seem to lessen nurses' responsibility for translating a treatment philosophy into action.

CONCLUSION

Nurses have indulged in considerable "buck-passing" when proposing solutions to our dilemma. Nursing service and nursing education hold each other responsible, and each accuses the other of influencing nursing students in ways that perpetuate the difficulties.

I propose that the burden of proof lies with each nurse in whatever position she functions. We can choose to be responsible professionals who determine our role in light of the needs of society, seek increasingly better ways of fulfilling the role, and assume full responsibility for our actions; or we can pursue our present will-o'-the-wisp path toward eventual professional oblivion.

REFERENCES

1. ALLPORT, GORDON W., "Pattern and Growth in Personality," New York, Holt, Rinehart and Winston, p. 184, 1961.

2. GREENBLATT, M., YORK, R., and BROWN, E. L., "From Custodial to Therapeutic Care in Mental Hospitals," New York, Russell Sage Foundation, 1955.

3. HAYS, JOYCE S., "The Psychiatric Nurse as Sociotherapist," American Journal of Nursing, Vol. 62, pp. 64-67, 1962.

4. JONES, MAXWELL, "The Therapeutic Community," New York, The Basic Books, 1953.

5. LAMBERTSON, ELEANOR C., "Education for Nursing Leadership," Philadelphia, J. B. Lippincott Co., p. 49, 1958.

6. MALONEY, ELIZABETH, "Does the Psychiatric Nurse Have Independent Functions?" American Journal of Nursing, Vol. 62, pp. 61-63, 1962.

7. MULLANE, MARY K., "Proposals for the Future of Nursing," Nursing Forum, Vol. 1, pp. 73-84, 1962.

8. NORRIS, CATHERINE M., "Administration for Creative Nursing," Nursing Forum, Vol. 1, p. 97, 1962.

9. PEPLAU, HILDEGARDE, "Interpersonal Techniques: The Crux of Psychiatric Nursing," American Journal of Nursing, Vol. 62, pp. 50-54, 1962.

10. PEPLAU, HILDEGARDE, "Principles of Psychiatric Nursing" in "American Handbook of Psychiatry," Vol. II, New York, The Basic Books, pp. 1847-1853, 1959.

11. SARBIN, THEODORE R., "Role Theory," Chap. 6 in "Handbook of Social Psychology," Gardner Lindzey, ed., Cambridge, Massachusetts, Addison-Wesley Publishing Co., Inc., p. 225, 1954.

12. STANTON, H., and SCHWARTZ, M. S., "The Mental Hospital," New York, The Basic Books, 1954.

TEAM MORALE, TIME UTILIZATION, AND TREATMENT EFFECTIVENESS*

BRENDA A. DICKEY, M.A.,** *Research Analyst*
Fort Logan Mental Health Center, Denver, Colorado

The investigation reported here is a partial description of a larger study which has addressed itself to the relationships between morale and treatment effectiveness in a mental hospital setting. Two trends of research have contributed to the thinking which has guided the study; one stemmed from the pioneering work of Stanton and Schwartz (9), Belknap (1), and Caudill (4), while the other derives from industrial psychology and group dynamics studies, such as those illustrated by Cartwright and Zander (3) and Herzberg (7).

The former approach described in detail how mental hospital structure could affect its functioning, especially with regard to how intrastaff conflict could produce regressive and acting-out behavior in the patient population. These studies were also characterized by being nonquantitative in nature and drew pictures of only one hospital's operation over periods of time.

The second approach has attempted to search out factors influencing group productivity, but has used varying techniques and subjects of investigation. For instance, the industrial psychology researches have tended to attack the problem through testing large groups of factory workers, and the group dynamics studies have leaned toward using small, artificially created groups which labored over solutions to problems provided by the experimenter.

The writer believed that there were many parallels between these two apparently diverse trends: that factors which had been

---

*Based upon a portion of the author's dissertation at the University of Colorado conducted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

**Box 188, Fort Logan, Colorado.

Journal of the Fort Logan Mental Health Center, Vol. 1, pp. 103-116.

found to affect the efficacy or quality of group members' performance in arriving at problem solutions could also be found to affect staff members' functioning in the mental hospital situation. It was thought, for example, that "morale" could be considered synonymous in some respects to "intrastaff conflict"--that while the two terms are certainly not interchangeable, one can consider low morale as being indicative of high intrastaff conflict.

Also, the mental hospital functions with the goal of producing patient improvement, and its ultimate concerns are with treatment effectiveness. In a sense the staff is faced with a problem solving situation in human relations, and the staff's performance can be measured by the products of the therapeutic program--how many patients are discharged, how many readmitted, whether symptom alleviation is accomplished, and the like. Therefore, the second parallel between the two trends of research was seen as occurring between treatment effectiveness on the one hand, and group productivity on the other.

The approach of Stanton and Schwartz (9) and others has successfully established the existence of a general relationship between intrastaff conflict and patient disturbance, such that the greater the conflict, the larger the amount or frequency of patient disturbance one may expect to find. This positive association can alternatively be stated as giving support to the notion that high intrastaff conflict is related to treatment ineffectiveness.

The industrial psychologists' and group dynamics' researches have similarly established the general relationship between group morale and productivity. Using a variety of techniques and settings, they have demonstrated that low morale tends to be associated with poor productivity and poor problem-solving performance. The overriding hypothesis of this study, then, was that relative treatment ineffectiveness in a mental hospital setting would be associated with low staff morale.

Results from the industrial psychology and group dynamics studies have also shown that if personal involvement in the group's goal can be produced or intensified, then the relationship between morale and productivity can be strengthened. Such involvement can be facilitated through techniques such as group discussions on means of attaining the goal and talks about ways in which individual group members can contribute to the problem solving.

Phrased in yet another way, the relationship of a group's morale to its level of productivity can be heightened if the individual group members are personally committed to the task and their part in it.

In many ways the Fort Logan Mental Health Center provided an excellent setting for testing the hypothesized association between morale and treatment effectiveness. In line with the preceding paragraph, the underlying philosophy of the center's therapeutic community orientation fosters increased involvement on the part of staff members in attaining the center's goal, which is, of course, patient improvement. By leveling authority procedures, blurring roles, and presenting opportunities for all staff members to express their views on treatment (2, 8), the clinicians are encouraged to become deeply and personally involved in the treatment process. Regardless of disciplinary affiliations and background, they are permitted, even urged, to take on duties and responsibilities which would be outside their typical job domains in a custodial institution. In this setting, the clinicians feel that treatment failures are caused by poor staff functioning as well as insufficiencies or inadequacies of the treatment program itself.

The study reported here was not designed to investigate the direction of the relationship between morale and therapeutic effectiveness. That is, while it *did* attempt to establish the existence of such a relationship in a therapeutic community setting, it did not attempt to determine which factor occurred first in time and caused the other.

Many studies have used only an attitudinal measure of morale. By this, it is meant that subjects indicate on a paper-and-pencil questionnaire how they feel about such factors as their job satisfaction and accomplishment. Because overt behavior does not necessarily bear a one-to-one relationship with verbally expressed opinions and beliefs and because it was felt that the addition of another variable would add explanatory power to the total picture, the factor of time utilization was introduced into the study. While the attitudinal measure of morale could be termed an index of subjective morale, time utilization was thought to provide a more observable way in which morale could be manifested. Time utilization thus can be said to constitute a more objective measure of morale. It also is a vehicle for measuring how an institution's facilities are used by a specific team. Despite similarities in the

ways teams operate at Fort Logan, there are differences as well. These differences were assumed to be partially reflected in the way teams allocate their time among various activities.

Using the three variables of subjective morale, therapeutic effectiveness, and time utilization, it was predicted that:

1. Subjective morale is positively related to time utilized in areas concerned with patient contact.

2. Time spent in patient contact is positively related to therapeutic effectiveness.

3. Time not spent in patient contact is not related to therapeutic effectiveness.

In summary, it was thought that high morale would be associated with greater amounts of time spent in working with patients and with greater degrees of patient improvement.

METHOD

Subjective morale was measured by means of the Staff Attitude Survey, which is an instrument designed by the Psychology Department at the center. It was originated and administered to the staff of the three treatment teams in existence during the summer of 1962, and was used again in the context reported here in April 1963.

The survey is made up of 81 items,* composed of 20 statements in each of four areas. The areas were leadership, communication, role and status, and team effectiveness, and were selected by the Psychology Department as the most relevant domains for appropriately assessing staff morale in a therapeutic community. Each statement was scored on a 4-point scale, with a score of 4 ("strongly disagree") indicating the most favorable, high-morale response to the item. Individual morale scores were obtained through summing the responses to the 80 items, and calculating an average team score.

---

*Item number 77 was not included in these areas, nor in the analysis. It reads, "People who take up staff time with long, involved questionnaires should have them stuffed down their throats."

Test-retest reliability was calculated on scores of the 32 people who took the survey both in 1962 and 1963. The Pearson *r* for these pairs of scores was .561, *p* less than .01. There was no significant difference between mean morale scores for the 32 people who took the test both times. The 1962 average was 245.47, while the 1963 average was 244.28.

For purposes of this study, the Staff Attitude Survey was administered at one of the regular staff meetings with the explanation that the administration wanted to see if morale had changed appreciably over the intervening year of the institution's operation. By using this explanation, it was hoped that the staff would not become aware that the survey was being used to relate team morale to therapeutic effectiveness. About three-fourths of the staff completed the survey in this group session. The remainder, most of whom could not attend the group session because of duty in the cottages, vacations, or night duty, turned in questionnaires during the following two weeks. Only one staff member failed to turn in a completed questionnaire within the two-weeks time limit allowed.

The individual surveys were scored in the Record System Project* by the writer, and the IBM section of the project punched the data and made the necessary tabulations of the data, from which team means and other statistics were obtained. As a service to the institution for having allowed the writer to use the survey in the study reported here, a partial analysis of the questionnaire was made along the lines that the center would find most interesting, and a report of this analysis was presented at a staff meeting in May.**

---

*The Record System Project is an NIMH grant-supported endeavor (No. 5-11 MH00931, Paul R. Binner, Ph.D., Principal Investigator) to devise and carry out procedures for collecting, retrieving, and analyzing data which are potentially useful for research in a mental hospital setting. It is a project unique in many respects, not the least of which is the fact that data have been collected on every patient treated at the center since the inception of the hospital. The system contains vital information on all aspects of patient progress, status and treatment, including demographic, historical, physiological, psychological and neurological data. A further description of the project is given in this Journal, pp.117-127.

**Copies of this report are available upon request.

The Time Utilization Survey was made of all staff members on the various teams shortly after the Staff Attitude Survey had been given. It asked each person to estimate the amount of time he spent per week in 17 different activities. These were: formal work with patients, informal work with patients, admission evaluations, passing medications, work with patients' families, teaching, training, team conferences, informal staff sessions, other conferences, committees, research, paper work, traveling, community work, telephoning, and other. The total number of hours per week spent by all the regular staff members on each team was found, and then the percentage of this total was found for each item for each team. Since amounts of time in many areas were extremely small, only those items were used which accounted for a substantial portion of the teams' time and, in addition, were concerned with patient contact. These items represented time spent in a) formal patient work, b) informal patient work, and c) admission evaluations. Time study data was made available through the cooperation of the Record System Project, along with [redacted] listings of information requested by the writer. The project also provided the necessary listings of MACC data described in the following paragraph.

Behavioral changes during hospitalization constituted a measure of therapeutic effectiveness. The Record System Project routinely collects judgments on all patients according to the MACC Behavioral Adjustment Scale (5, 6). Ratings are made at one week, one month, three months, at transfer from one treatment modality to another (such as transfer from inpatient to day-patient status) and also at discharge. The Record System Project instructs teams that two raters are to independently make each set of judgments, so that checks can be made occasionally on interrater reliability. Ratings are made by various personnel, depending upon team practices in this regard. In some teams ratings are made predominantly by nurses and technicians, while in others they are done by all staff members, including the team leaders, psychologists, and social workers. Interrater reliabilities were calculated for a sample of raters and were found to be significant at the .05 level.

Behavioral change scores were obtained by taking algebraic differences between MACC ratings over at least a one-month interval for all patients who were on a team between January 1, 1963,

and April 30, 1963. A positive change score thus indicated improvement. Where there was a choice between various sets of ratings, the most recent pairs were used. Other criteria of usability were: a) patient's diagnosis was not organic; b) ratings were submitted for coding in the Record System Project within a reasonable length of time after the date when the ratings should have been made; and c) independent ratings were not more than 10 points apart.

RESULTS

Subjective Morale

Table 1 presents the means, standard deviations, and ranked means for the scores obtained on the Staff Attitude Survey of the six treatment teams.

TABLE 1

STAFF ATTITUDE SURVEY, APRIL 1963

TEAM	MEAN	STANDARD DEVIATION	N	RANKED MEANS
A	247.95	14.02	19	3
B	238.77	13.39	13	6
C	246.69	19.08	16	5
D	253.76	15.83	17	1
E	249.87	18.00	18	2
F	246.80	17.41	15	4

Team Time Utilization

Table 2 gives the percentage of time spent per week in the following activities: formal patient work, informal patient work, and admission evaluations. It also presents the ranks of the teams for each of these categories of time utilization.

TABLE 2

TEAM TIME UTILIZATION

TEAM	FORMAL PT. WORK		INFORMAL PT. WORK		ADM. EVAL.	
	% Time	Rank	% Time	Rank	% Time	Rank
A	21.2	4	25.0	1	1.6	5
B	16.7	6	19.2	3	1.3	6
C	19.0	5	16.3	4	2.7	3
D	22.3	1.5	14.2	2	3.3	4
E	21.8	3	13.4	6	2.8	2
F	22.3	1.5	20.4	5	1.7	1
Tot. Hrs. per Week	560		520		520	
N	14		13		13	

Treatment Effectiveness

In order to obtain the measure of behavioral change during hospitalization, the *changes* in MACC scores over at least a one-month period preceding the administration of the Staff Attitude Survey were found, using the criteria outlined earlier. Table 3 shows the means, standard deviations, and ranked means of the change scores, with the larger positive figures indicating the more therapeutic gains.

TABLE 3

CHANGES IN MACC RATINGS, JANUARY 1 - MARCH 31, 1963

TEAM	MEAN CHANGE	S.D.	N	RANKED MEANS
A	3.09	9.0	22	4
B	-1.22	7.4	9	6
C	2.58	6.1	26	5
D	5.00	9.1	27	2
E	5.47	7.6	15	1
F	4.64	4.7	22	3

Relationships between Subjective Morale, Team Time Utilization, and Treatment Effectiveness

Significant positive relationships were expected to be found between the Attitude Survey and a) time spent in formal patient work, b) time spent in informal patient work, c) time spent in admission evaluations, and d) MACC changes. Positive relationships were also expected to be found between MACC changes and a) time spent in formal patient work, b) time spent in informal patient work, and c) time spent in admission evaluations. In all, seven statistically significant relationships were anticipated.

Table 4 summarizes the Kendall *tau's* that were obtained for the compared ranks involved. Only those *tau's* which reached a significance level of .068 or better were regarded as statistically significant.* Therefore, five of the seven predicted relationships were confirmed.

TABLE 4

EXPECTED PRESENCE OF RELATIONSHIPS

Attitude Survey:	Formal Patient Work	.691,* p less than .068
Attitude Survey:	Informal Patient Work	0
Attitude Survey:	Admission Evaluations	.600, p = .068
Attitude Survey:	MACC Changes	.733, p = .028
MACC Changes:	Formal Patient Work	.691,* p less than .068
MACC Changes:	Informal Patient Work	0
MACC Changes:	Admission Evaluations	.600, p = .068

*Corrected for one pair of tied ranks on one variable.

*The selection of .068 as the alpha level was made because the tables used to obtain probability values for tau contain exact p values for various S's obtained. An S of 9 (tau of .600) = p of .068, and an S of 11 (tau of .733) = p of .028. The traditional alpha is, of course, .05, and the decision was made to adopt the S value that was closer to this figure.

DISCUSSION

The results obtained in this limited study of the relationships between treatment team morale, time utilization, and therapeutic effectiveness have, in general, supported the hypotheses that predicted positive associations among the three variables. The higher a team scored on the Attitude Survey, the more time it tended to spend in formal patient work and in admission evaluations, and the more favorable were the MACC average change scores for its patients. Also, the more time a team spent in formal patient work and in admission evaluations, the more favorable were the MACC average change scores obtained.

It will be recalled that the time utilization categories were introduced to provide a more behavioral measure of morale. They were also to provide a measure of how the teams used the available resources of the institution and how these resources were integrated with the underlying philosophy of the center. Because the time utilization categories did not assess morale alone, but also measured other factors, it is reasonable to expect that they would not yield as strong a relationship with the other variables as either morale or therapeutic effectiveness. This prediction was not made at the outset of the study, because statistical techniques do not permit a test of the hypothesis when the *N*'s are so small. However, the correlation obtained between the Attitude Survey and and the MACC change scores was the highest, and the ones involving the time utilization categories were smaller. Whether or not the difference is statistically significant is a moot point.

It is also interesting to note that the correlations which did not reach significance were those which involved informal patient work. Since the therapeutic community might be thought to operate on the assumption that *all* contact with patients is potentially therapeutic, why does this type of staff-patient interaction not show an association with the MACC change scores? A few clinicians who were asked to speculate on this lack of relationship have suggested that informal patient work is composed of two kinds of contact. One is the potentially useful kind which consists of short, casual conversations carried on in halls and game rooms. The other, more common type of informal contact is less pleasant in tone and content. Such ungratifying patient-staff

contacts are initiated by certain patients mainly to "bug" or twit the staff member and can be characterized as mild forms of harassment. The twitting is typically handled in as therapeutic a manner as possible, especially if morale on the team is high. If morale is low, however, harassment from patients can further diminish staff morale and can be construed as a symptom of patients' disturbance when it occurs frequently. Assuming that much informal patient work consists of this unpleasant and usually unproductive harassment, it is no wonder that this category of team time utilization was found to bear little relationship to either morale or therapeutic effectiveness.

Caution should be exercised in generalizing from these results. While it seems difficult to deny that some association between level of team morale and treatment effectiveness has been established, it should be remembered that this study has used a restricted definition of these two variables. Morale can be measured in other ways--personnel turnover and absenteeism are but two commonly used by industrial psychologists. Alternative ways of measuring patient improvement are likewise possible: length of hospital stay, readmission rates, discharge rates, clinical judgments of response to treatment at the time of discharge, and follow-up data obtained after discharge. Factors like patient-staff ratios and pleasantness of working conditions, which may alter the strength of the morale-therapeutic effectiveness relationship, have not been explored.

While the predictions have been born out in a therapeutic community setting, there is no reason to suspect that the same association would be found in a custodial institution. In fact, one might expect that no relationship could be obtained between these variables. Staff involvement in the treatment program of a custodial hospital is probably much less, and results generated from assessing that type of environment might be similar to those found in factories where workers "just do a job." Institutions like the Fort Logan Mental Health Center tend to foster a spirit that makes employee job satisfaction highly pertinent to the institutions' functioning, but custodial institutions may tend to encourage the type of working environment that sees job satisfaction as an unnecessary "extra" to good job performance.

The study reported here assumed at the outset that there was some commonality in meaning between intrastaff conflict and morale--at least to the extent that a high degree of conflict was not likely to be found concomitantly with high morale. However, the significance of the obtained correlations should not imply that high intrastaff conflict was present on the lower ranking morale teams. Group dynamics studies, especially those done with creative groups, such as "brainstorming" groups, have indicated that a certain degree of intragroup dissension facilitates arriving at more imaginative, as well as more constructive, solutions to problems. While there is undoubtedly some relation between intrastaff conflict and morale, it is probable that the presence of dispute is in no way totally inimical to obtaining good results in treating patients. There probably is an optimal amount of conflict for the most effective performance of a particular team's program, but detailed exploration of this question has not yet been attempted.

SUMMARY

This study was an attempt to relate the variables of team morale, time utilization and treatment effectiveness in a therapeutic community setting. Specifically, the predictions were made that morale should be positively associated with both team time utilization and treatment effectiveness, and that team time utilization should also be positively related to treatment effectiveness. Thus, the higher a team's morale, the more time should be spent in working with patients and the better should be the therapeutic results. More time spent in working with patients should also be associated with better therapeutic results.

Morale was measured by means of the Staff Attitude Survey, which was administered to all clinical staff members working in a therapeutic community, the Fort Logan Mental Health Center. Team time utilization was measured by calculating average percents of time that staff members reported they spent in varying patient-oriented activities. Treatment effectiveness was assessed by means of the MACC Behavioral Adjustment Scale, where changes in patients' ratings were calculated over at least a one-month

period. Treatment effectiveness was indicated by positive change scores.

Six treatment teams were ranked from highest to lowest averages on these three measures and all seven correlations between pairs of rankings were calculated by using Kendall's *tau*. Five of the seven predictions made were confirmed. The Staff Attitude Survey was found to be positively related to time spent in formal patient work, time spent in admission evaluations, and favorable MACC change scores. Time spent in formal patient work and in admission evaluations was also found to be positively associated with favorable MACC change scores.

On the basis of these results, it was concluded that teams ranking high in morale tend to be characterized by staff members on these teams spending a greater percent of their time in formally working with patients and in doing admission evaluations. High morale is also related to greater therapeutic effectiveness, and greater therapeutic effectiveness is associated with team staff members spending more time, on the average, in formal patient work and in admission evaluations.

REFERENCES

1. BELKNAP, I., "Human Problems of a State Mental Hospital," New York, McGraw-Hill, 1961.

2. BONN, E. M. and KRAFT, A. M., "The Fort Logan Mental Health Center: Genesis and Development," Journal of the Fort Logan Mental Health Center, Vol. 1, No. 1, pp. 17-29, 1963.

3. CARTWRIGHT, D. and ZANDER, A., "Group Dynamics," New York, Row Peterson, 1953.

4. CAUDILL, W. A., "The Psychiatric Hospital as a Small Society," Cambridge, Massachusetts, Harvard University Press, 1958.

5. ELLSWORTH, R. B., "The MACC Behavioral Adjustment Scale Manual," Los Angeles, Western Psychological Services, 1957.

6. GUERTIN, W. H. and KINGMAN, A. D., "A Factor Analytically Devised Scale for Rating Activities of Psychiatric Patients," Journal of Clinical Psychology, Vol. 15, pp. 32-36, 1959.

7. HERZBERG, F., NAUSNER, B., and SNYDERMAN, B., "The Motivation to Work," New York, Wiley, 1959.

8. JORDAN, L., "Patient Attitudes toward Staff Roles," Journal of the Fort Logan Mental Health Center, Vol. 1, No. 1, pp. 7-17, Fall 1963.

9. STANTON, A. H. and SCHWARTZ, M. S., "The Mental Hospital," New York, Basic Books, Inc., 1954.

THE FORT LOGAN RECORD SYSTEM

PAUL R. BINNER, PH.D.,* *Assistant Chief*
and BERNARDO GAVIRIA, M.D., *Assistant Chief*
Research Department
Fort Logan Mental Health Center, Denver, Colorado

INTRODUCTION

It has been widely recognized that a great number of psychiatric institutions cannot make full use of the information contained in their records. This is not always due to deficiencies in the type or amount of data collected, which in many instances are of enormous clinical and investigative value. The most serious obstacle to proper utilization of the records in many cases stems from inadequate storage, systematization, and retrievability of the information.

This paper will briefly describe the operation of the record system at the Fort Logan Mental Health Center and will make some comments about its impact on the hospital program.

The project described here has been concerned primarily with the design of an efficient and comprehensive hospital record system for a psychiatric treatment facility set up along the basic lines of a therapeutic community (1).

To meet the basic demands of such a project, effective methods for coding, storing, and retrieving information are needed. Equally necessary, however, is the incorporation within the system of the clinical judgments made about each patient in the course of his hospitalization. The record system, therefore, has given special attention to the information generated by the clinicians in direct contact with the patient.

Because planning of the record system began months before the center was in operation, clinical information has been collected

*Box 188, Fort Logan, Colorado.

Journal of the Fort Logan Mental Health Center, Vol. 1, pp. 117-127.

since July 1961 when the Fort Logan Mental Health Center opened its doors to psychiatric patients from the Denver metropolitan area.*

OPERATION

The core of the project's operation consists of the following functions: a) the development of methods for collecting and storing information, b) the organization of analyzing equipment, and c) the development of the content of the record system.

Collection and Storage of Information

In the process of collecting information, one of the first steps is that of deciding which type or types of documents to adopt. For the purposes of this record system, where a great variety of information is gathered from diverse sources, several types of forms have been designed. The basic forms used are checklists, multiple-choice questionnaires, or a combination of the two; their common feature is that content interpretation of clinical reports by the record system staff is eliminated or reduced to a minimum. Because of the diversity in design and function of the forms, detailed explanatory outlines and guides for their use have been devised. Changes which have proven useful or necessary in the course of the last two years also have been incorporated. Both the planning and the modification of the forms have required close collaboration with the clinical disciplines.

The data from the different forms are stored in IBM cards. These are punched in some cases directly from the form used by the clinician (self-coding forms); in many instances, however, the data have to be coded by record system personnel before punching the information into cards.

Equipment

On the basis of conferences with various representatives of data-processing equipment and with state agencies, it was

*Since November 1961, the project has been partially supported by the National Institute of Mental Health, Grant No. 5-11 MH00931.

concluded that a basic IBM installation that would make it possible to punch, sort, and tabulate the data intended for collection would suit most of the project's immediate needs. The equipment chosen was not expected to function anywhere near capacity in the beginning, but it seemed highly advantageous to start with a mechanized system, rather than trying to convert from other forms of records at a later date. Although there were a relatively small number of records in the beginning, buildup was rapid. Within a short time it was apparent that to handle the demands for information, analysis, and consultation in a nonmechanized way would not have been possible. This becomes especially true when the need for rapid access to the records of all patients, not just to those of current patients, is taken into account.

The equipment now being used by the project consists of the following machines: 024* key punch, 056 verifier, 082 sorter (450 CPM), 514 reproducing summary punch, 548 interpreter, 402 alphabetic accounting machine with digit, selector attachment, and 085 collator.

These machines enable the record system to arrange and present, quickly and accurately, the information collected. This means that listings and tabulations of data stored, as well as sums, distributions, and collation of information recorded in many different documents can be easily obtained. As familiarity with the equipment and its capabilities has increased, additional ways of improving the organization and presentation of the data have been found. There are many other procedures which would enhance the ease and accuracy of collection and analysis, and the feasibility of the record system using them is being studied. In the future an important contribution to an increasing capacity to analyze data should come from the use of computers. It seems probable that a sizable volume of analyses can be made with a relatively small amount of computer time and expense. To explore this possibility some members of the project staff have attended information or training courses in the use of computers.

Content

In developing the content of the record system, the data to be kept on cards are considered a skeleton of the total information

*The numbers indicate IBM machine types.

stored in the conventional record. This skeleton, which may not be adequate for all the purposes of the charts, such as legal requirements, may be supplemented to any desired degree with a narrative record in the chart. However, the purpose of the stored information is to provide easy access to all basic information; this, in turn, should make possible the detailed examination of any special type of raw data. The work of planning the content has been directed at outlining the areas of information to be covered and organizing the data obtained. At the same time it has tried to make this information as complete as possible, thus minimizing the amount of narrative necessary.

Data now being collected may be ordered into five classes: a) demographic material, b) measures of prehospitalization and posthospitalization adjustment, c) therapeutic experiences in the hospital, d) clinical evaluation procedures, and e) outcome experiences. Not all of these areas are covered to the same extent; while in some it can be said that information is comprehensive and detailed, in others it is still limited and general.

Demographic material. The demographic data are intended to provide the kinds of information needed to group individuals on the basis of personal, social, or economic characteristics. This is the kind of information often gathered by basic surveys of the general population, such as those conducted by the United States Census Bureau. These data have special value in the comparison of patient populations with other groups.

1. Data collected: The data collected may be subdivided into the following categories: a) individual identification, b) sources of referral, c) admission and legal status, d) occupational information, e) marital information, f) religion, g) education, h) geographic information, i) military service information, j) social and medical assistance, and k) historical information.

2. Manner of collection: Demographic information usually is furnished by the patient in his application for admission. The admissions clerk obtains any necessary data which may have been omitted.

Prehospitalization and posthospitalization adjustment. This is measured by a group of scales designed to obtain an estimate of the patient's functioning before and after hospitalization (2). The information has been scaled and coded for quantitative evaluation

so that comparisons between past and current functioning in certain areas will be facilitated.

The material supplied by these scales is too limited in scope for any intensive follow-up of patients who have left the hospital. In evaluating effectiveness of hospitalization or different kinds of therapy, additional sources of information will have to be tapped, and the amount and range of data to be collected will have to be increased.

1. Data collected: The areas of information covered by the scales include the following: a) social and family relations, b) social productivity (work, school, and other socially useful behavior), c) self-management (personal care and conduct), and d) antisocial behavior. The posthospitalization scale includes questions regarding any other institutional experiences following the patient's release. Information identifying the informant is also obtained.

2. Manner of collection: The scales are given or mailed to the two informants designated by the patient. The prehospitalization scale is used at the time of admission, while the posthospitalization scales are used at given intervals after the patient's discharge.

Therapeutic experiences in the hospital. Under therapeutic experiences are grouped all activities instituted or encouraged by the hospital staff in the belief that they will improve the patient's condition. These activities may be specific and formal, or they may be a part of the general social atmosphere of the hospital. As a whole, they constitute one major reason for the center's existence. Therefore, it is of the greatest importance to obtain systematic records of the therapeutic experiences undergone. Unfortunately, this is the area in which the information collected by the record system is most fragmentary and incomplete. While it would be most desirable to keep a detailed record of all treatments given, including drugs, physical therapies, and psychotherapy, the only reports now being collected are those on occupational therapy, recreational therapy, and work therapy participation. In addition to data now gathered describing the movement of each patient through different treatment modalities, such as inpatient care or day hospital, an account of the patient's social activities and other hospital group projects should be obtained. Although exten-

sive reporting of all therapeutic experiences is contained in each patient's chart, they are not yet being stored by the data system. This is due to the lack of appropriate methods for standardization and coding of this material. Being considered now are group psychotherapy reports, monthly team progress notes, family group summaries, and an ongoing record of medications.

Clinical evaluations. In any psychiatric setting it is customary to involve the patient in a series of evaluations to determine the nature and extent of his disturbance and, on the basis of this, to plan a course of action that will be maximally beneficial to the patient. This evaluation involves at least one, and often three, of the major clinical disciplines. It usually includes a psychiatric workup and a social worker's assessment of the current situation and historical material; psychological examinations of varying complexity are often carried out. These evaluations are of the utmost importance in many decisions involving the patient and in the utilization of hospital resources; in addition, they are expensive and time-consuming operations. It is, therefore, appropriate that they be recorded in such a way that they can be effectively evaluated.

It is in the area of clinical evaluations that the record system goes beyond the scope of almost any other system known to the authors. Data collected cover most areas of clinical evaluation. While detail and accuracy are given special attention, it is not difficult to recognize that this is a hard task. Defining the items to be measured and the criteria for measurement poses special difficulties. From the clinician it demands adherence to strict, and sometimes arbitrary, rules and procedures for the sake of agreement and consistency. From the record system it demands continuous clarification and standardization, so that the amount of paper work required from the clinician is reduced and simplified, rather than increased and made more complex.

1. Data collected: The following evaluations are presently reported in self-coding checklists or questionnaires: a) mental status examination, b) psychiatric diagnostic and prognostic evaluation, c) treatment plans and recommendations, d) physical, neurological, and endocrine examinations, e) psychological examination, f) social history, g) hospital behavior and adjustment

(using the MACC* scales), and h) suicidal behavior. Information from other areas will be added eventually, particularly laboratory reports and records of special studies.

2. Manner of collection: The needed data are gathered from the professionals who make the judgments involved. In one case of the MACC, two observers (nurses and/or technicians) record their observations independently at regular intervals during the patient's stay at the center.

Outcome experiences. This information is intended to answer the question, "What happened to the patient?" The general question may be posed at different times, according to the phases of the patient's course. An evaluation of outcome, therefore, may be necessary a) when there is a major change in status within the hospital, as a result of changes in the patient's condition, or b) when the patient leaves the hospital, or c) at various intervals, after the patient has been discharged from the hospital. Summaries at the time of transfer or discharge are being compiled on every patient. The data include diagnostic and prognostic information, summary of treatment received, response to therapy, attitudes toward treatment, living arrangements, and recommendations. The only outcome information after discharge comes from the post-hospitalization scales described before.

At present the hospital operates two divisions: the Psychiatric Division and the Alcoholism Division. The content of the records varies according to specific differences in the aims and methods of each division. An important part of the planning by the record system involves the development of appropriate data collection and storage for the medical-surgical, geriatric, and children's psychiatric programs.

EXPANSION

The need for extending the present system to future programs has been mentioned. Already the data system project has come

*MACC stands for motility, affect, cooperation, communication—the areas originally covered by the scale. The areas of adjustment included in the revised version are mood, cooperation, communication, and social contact.

into close contact with areas of hospital functioning other than patient's records. As a result, some new developments have taken place which were not anticipated at the beginning; for example, the personnel department embarked on an investigation of the causes of staff turnover by studying characteristics of employees terminating employment, and the nursing department is developing a system for the evaluation of the technician training program.

The data already collected have opened the way for administrative studies, such as a survey of time utilization by the clinical staff. Research by students in different disciplines has been carried out in conjunction with the record system. Pilot studies are being conducted, such as the one involving the nursery school, which records and analyzes behavior data on children of patients attending the day hospital.

The data system has also been called on to provide consultation services for community agencies, including the statewide mental health planning project. Information has been prepared about the organization of the system to answer inquiries from other institutions interested in developing automated record keeping.

SIGNIFICANCE

One vital function of the data system is to make possible direct feedback to the clinicians who provide the information. With minimum expenditure of time and effort, the clinician has at his disposal an enormous amount of information that, under different circumstances, would require a long and frustrating search through the records. Furthermore, the systematic collection and ready retrieval of the data makes it easier for the clinical and administrative staff to judge the effects of the therapeutic efforts on behalf of the patient, an assessment of paramount importance in planning for the future.

From the standpoint of program evaluation, the information gathered in the first two years of operation has already played a part in clinical and administrative decisions. For instance, data about the characteristics of day patients and inpatients have helped determine the optimal population of a team, the number of patient beds needed for 24-hour care, and the need for the phasing

in of new teams. As a result, accurate budget preparation and presentation have been made less cumbersome.

Even more important than learning about the effectiveness of treatment programs is the understanding and explanation of the results. For this reason one of the most significant and exciting aspects of the project is its research potential. The existence of this large body of information and of the available facilities for its analysis paves the way for diverse types of investigations. A partial list of research done includes studies on patients' attitudes and beliefs, social interaction, criteria of success and failure, length of stay, use of treatment modalities, and staff morale as related to therapeutic effectiveness. Some of these have been carried out by members of the research department; many others by individuals representing most of the disciplines of the clinical staff; others have been planned and conducted by graduate and undergraduate students affiliated with the hospital.

THE PROJECT AND THE CLINICAL STAFF

Considerable concern has been expressed at different times over possible resistances from the clinical staff to any changes in usual work routines required by the data system. The initial experiences, however, were gratifying. The clinical staff was sympathetic to the aims of the project and willing to endure the inconveniences entailed. Indeed, the first reaction was one of overenthusiastic acceptance, not without unrealistic expectations; the capacity of the system for quick feedback and definitive research results was overestimated. However, regular reports to the staff, using even the small amounts of data available in the early stages of the project, helped to illustrate the extent of analysis possible. These have consisted essentially of statistical presentations of the data collected.

Inevitably, some of the initial "honeymoon" atmosphere that surrounded the opening of the center has begun to wear off. Grumblings about forms and paper work are now heard, and resistance is evident. This may be related to the increased patient load accompanying the center's growth, as well as to the influx of new staff who were not as thoroughly informed of the aims and purposes of the hospital as the original staff had been.

One important side effect of the response to the record system has been an unexpectedly rapid evolution of forms. Almost every clinical service has pressed for revisions, some of which, following demands for over-all increases in paper work, were aimed at reduction in the amount of reporting required. The forms utilized by the record system, however, represent but a small part of those routinely used in the hospital. On other occasions, some clinicians pressed for greater accuracy and completeness. In both cases, people have been urged to wait until further experience indicates what modifications would really be necessary or advisable. In many other cases, where the need for improvement and updating has been evident, forms and procedures have been changed. A few of these revisions have been thoroughgoing, as in the mental status examination; here the original checklist was extended considerably as the users found that a resulting shortened narrative would mean a substantial saving in time.

This very important kind of development has come sooner than had been anticipated. Although it has created added burdens, this is the best sort of evidence of an active involvement between the clinician and the record system, and therefore must be nurtured.

EVALUATION OF RESULTS

It has been mentioned that the record system has already had considerable influence on some areas of hospital operation. At the same time, clinical considerations have produced changes in the plans and aims of the data processing project. Future communications, reporting on specific areas of investigation, will illustrate in more detail the results obtained with this kind of data collection and analysis.

However, the ultimate effects and benefits of the system will have to be gauged by answering questions like the following: a) Are the records complete and accurate? b) Are they collected with reasonable ease and minimal paper work? c) Can information be quickly retrieved and analyzed from the records? d) Does the clinical staff maintain an active enthusiasm for this type of record system? e) Has research been promoted? f) Has it been possible to suggest improvements in the evaluation and treatment of the

patients? g) Has the understanding of mental illness been furthered? If affirmative answers can be given, and if the clinical staff can agree, the data system is on the way to accomplishing its objective.

REFERENCES

1. BONN, E. M. and KRAFT, A. M., "The Fort Logan Mental Health Center: Genesis and Development," Journal of the Fort Logan Mental Health Center, Vol. 1, No. 1, pp. 17-29, 1963.

2. SEWELL, L., LEMKAU, P., and BERGER, D., "Medical Audit Plan for Psychiatric Hospitals," Unpublished Annual Report, Veterans Administration Hospital, Perry Point, Maryland, 1959.

PATIENT PARTICIPATION IN DECISIONS ON PASSES AND PRIVILEGE CHANGES

Jeanie Leahy, R.N.,* *Staff Nurse*, and
Elizabeth Stubbs, *Mental Health Technician*
Fort Logan Mental Health Center, Denver, Colorado

The Jefferson County Team at the Fort Logan Mental Health Center has tried to maximize the responsibility that patients assume for other patients on their team. One step in this direction has been the organization of a required group discussion and vote by patients and staff whenever a patient presents a request for a pass or a change of status.

In the early stages of the team's development, the staff reserved the right to grant requests for passes and status changes. This system had a number of disadvantages, including the excessive amount of time required to reach decisions on the many requests, the ease with which some patients were able to seduce the staff into granting requests, and the manner in which other patients were able to move through their treatment program without having any significant interaction with or responsibility for their patient peers.

Around June 1962 we encouraged patients to make their requests to the patients and staff of the entire team in our daily group psychotherapy meetings. Gradually the system evolved and procedures became more refined, so that at the present we have a special "Pass and Privilege Meeting" held twice each week. This meeting includes all the day hospital patients and inpatients who are present on the day of the meeting, together with all the staff. Any patient having a request for a special pass, privilege change, change of status, or reduction in number of days attending day

*Box 188, Fort Logan, Colorado.

hospital must assume the responsibility of presenting his request at this meeting. Following the presentation of the request, the group inquires into the patient's situation and current problems, discusses the pros and cons of the request, and finally votes on the request, with each patient and staff member casting a single vote. The final vote sometimes represents a decision and sometimes a recommendation. In voting on privilege changes, passes, and changes in day hospital attendance, a majority vote decides the issue. There is no staff veto, except in the case of involuntary patients. However, on issues such as change of status from inpatient to day hospital or final discharge from the center, the majority vote represents a consensus recommendation, with the final decision being left to the staff. In actual practice, staff members seldom have acted against a recommendation, even though they sometimes have disagreed with it.

As it is presently operating, the system has some drawbacks. There is always some patient who will vote in favor of any request, disregarding the possible harmful effects that the granting of such a request may have on the patient who makes it. Initially, when such cases arose, the staff actively intervened and pointed out the disadvantages and potential harm to the patient if the request were to be granted. It was not long before the majority of the group became more aware of these considerations and began to point out to each other behavior which was not acceptable. They then were able to refuse to grant requests which they felt would not be in the patient's best interests.

In our experience this system has had a number of advantages: a) It has been effective in teaching patients the criteria used by staff and peers in judging their behavior. b) It has mobilized group pressure towards cooperating with the rules and mores of the center's community. c) Since patients are unable to obtain passes or privilege changes until they share their plans and progress in treatment with the group, it has increased meaningful group interaction. This is especially true for the patients who are usually silent and withdrawn in group meetings. d) The patients take pride in their ability to make sound, important decisions, and thus assume real responsibility for the welfare of others.

RECREATIONAL THERAPY IN A DECENTRALIZED SETTING

CARL HOLLANDER, B.A.,*
Head, Recreational Therapy Department
Fort Logan Mental Health Center, Denver, Colorado

Recreational therapy departments usually are organized within a centralized structure which is relatively independent of the basic treatment unit. Patients are sent to recreational therapy to be exposed to planned individual and group activities under the supervision of the recreational therapy department. Following this period of activity, they return to their basic treatment units until they are sent to receive other forms of treatment.

When mental health facilities are decentralized, many departmental programs and organizational structures need to be modified. Because of the geographic and administrative decentralization at the Fort Logan Mental Health Center, recreational therapy programming must be adapted to the treatment philosophy of each independent psychiatric team.

The present Fort Logan recreational therapy staff consists of the Recreational Therapy Department director, a recreational therapist, a music therapist, and two assistant recreational therapists. This staff serves a current patient population of 613. Although the officially designated recreational therapy personnel engage in patient activities, this is not their major responsibility. Rather, they serve as recreational therapy consultants to the treatment teams, instructors for inservice training programs, and resource people for individual consultation. Most of the actual recreational therapy is planned and carried out by the staff of the treatment teams. Through classes in the applications of recreational therapy, clinical staff learn to increase the teams' skills in the utilization of recreational therapy.

In our experience this decentralized model has a number of advantages. First, recreational therapy is actually administered

*Box 188, Fort Logan, Colorado.

by the same treatment team which provides all the patients' therapies, and continuity of patient care is maintained. A second advantage is that recreational therapy is planned and carried out by those staff members who best know the patients. Thus, it is possible for the treatment team to modify and adapt a recreational therapy period to meet the needs of the patients on that particular day. If the other activities of the day revealed a great deal of pent-up hostility, for example, the activity for that day might be immediately designed to encourage the appropriate externalization of that hostility. A third advantage is that the members of the Recreational Therapy Department have been perceived as consultants and helpers available on demand rather than as outsiders who interfere with the patients' "real therapy."

A major disadvantage of this system has been that the recreational therapy is provided by people not specifically trained in this treatment modality. As indicated previously, classes in recreational therapy for clinical staff have been organized to help modify this situation. Hopefully, this will contribute to the development of clinicians with a broad therapeutic armamentarium, whose participation in recreational therapy will be enriched by their skill in both verbal and activity therapies, as well as by their intimate knowledge of the patients.

THE DEVELOPMENT OF A WORK THERAPY PROGRAM IN A NEW STATE HOSPITAL

DON MILES* *Head, Work Therapy Section*
and JACQUELINE DE TURK, *Rehabilitation Counselor*
Fort Logan Mental Health Center, Denver, Colorado

Work has long played a role in the patient activity programs of mental hospitals in many nations. In countries such as England, Holland, France, and Russia, meaningful, paid work often constitutes

*Box 188, Fort Logan, Colorado.

the major treatment effort of a hospital. In this country, patient work has typically been unpaid and often is important to the functioning of the hospital in areas of operation such as the laundry, bakery, and farm. Such work is thought to increase patient self-esteem, prevent regression, and facilitate rehabilitation. Relatively little attention, however, has been given to evaluating the observable results of an existing work therapy program. Verbal communication of theoretical principles and service goals seems ineffective without an operating program against which to test this information. In July 1963 the Work Therapy Section at Fort Logan Mental Health Center began developing a service program based on the concept that the workshop setting facilitates a form of interaction not duplicated elsewhere in the treatment program. Results from the first four months of operation point out certain problems, but generally have been rewarding.

With a staff of two rehabilitation counselors, two work therapists acting as workshop supervisors, a contract solicitor-business manager, and a secretary, the Work Therapy Section began work in a 70-year-old building with 7,250 square feet of floor space converted into large workshop areas. While our building was being renovated, we began placing patients in work around the hospital. With supervision from regular employees, patients worked in various departments, including kitchen, library, laboratory, warehouse, and housekeeping. Coordination of these activities was difficult to maintain, and communication of patient progress to the treatment teams was delayed and often inaccurate. However, such a program appeared to meet the needs of about 10% of the patient population. By late August, we began unpaid work groups in the workshop building. We also began offering vocational counseling and referal services to the State Employment Service and the Department of Rehabilitation.

Our caseload increased to about 25% of the patients. In early October we began negotiating with community business concerns and have been successful in obtaining a variety of contract work. This includes packaging novelties, punch-press operation, building wooden pallets, addressing, stuffing, and mailing envelopes, compiling a catalog for a fabric manufacturer, and other work. Patients work in small groups and are paid on a group or individual piece

rate. They also meet once a week for a group session to discuss their work experiences. Work therapy staff send weekly performance rating sheets to the treatment teams and attend team meetings at least once a week. Present work therapy caseload is nearly 40% with indications that, if permitted, it will become 100% on some treatment teams.

Our experience indicates that developing a work therapy program in a new state hospital has certain advantages and problems compared with developing a similar program in an older, established hospital. One advantage is that we do not have chronic, hospital-habituated patients. We see patients fresh from the community and find very few who have never developed work skills or who have lost them. Yet, many of these patients who have a trade or profession still have employment problems. They are often unable to attain working group membership because of their flattened perceptiveness to the social cues which should lead to conformance to group norms. We believe that we have been able to overcome some of these deficiencies through the use of interdependent task groups, group piece rate, and the work-oriented group discussions. It is also an advantage that all patients are involved in an active treatment program outside work therapy. Decentralization presents some problem in that we must coordinate our efforts with those of seven or more different treatment teams as opposed to fitting into a single program in the centralized hospital.

Much of our program still needs to be developed. As this development proceeds, we feel that it will be important to conduct an ongoing evaluation project. Toward this end, we have a research grant application pending with the National Institute of Mental Health, and we are currently undertaking some pilot research. Some of the variables which we are studying relate work therapy experience to functioning in the hospital and after discharge, personality organization, hospital dependency, and the nature of clinical judgements in work therapy referrals. As part of the research design, every admission to Fort Logan enters one of three groups: a) immediate work therapy, two hours per day, b) no work therapy at any time, and c) work therapy when and if referred by the treatment team. Later reports will explore some of the research findings.

LENGTH OF STAY AT THE FORT LOGAN MENTAL HEALTH CENTER: Length of Stay Statistics of Psychiatric Patients Discharged in the First Two Years*

PAUL R. BINNER, PH.D.,** *Assistant Chief, Research Department*
and PAUL R. POLAK, M.D., *Chief, Research Department*
Fort Logan Mental Health Center, Denver, Colorado

INTRODUCTION

Although length of stay is a commonly used indicator of hospital functioning (2), it has clear shortcomings. Short stay may indicate premature discharge, for example, and long stay could be associated with good outcome. Later reports in this series will examine the relationship between length of stay and response.

Since the Fort Logan Mental Health Center has only been in operation a little over two years, this initial report will survey length of stay statistics of all*** psychiatric patients discharged from the center during its first two years of operation, from July 1961 through June 1963.

The average length of stay reported in Table 1 represents the total number of calendar days on the books of the institution of all discharged patients, divided by the number of patients discharged. "Calendar days" refers to the number of days that elapse between the date of a patient's admission and the date of his discharge, and, therefore, may include more days than he was actually in

---

*This study was based on data supplied by the Fort Logan Record System Project. The Record System is supported in part by Public Health Service Grant No. 5-R11 MH00931 from the Institute of Mental Health.

**Box 188, Fort Logan, Colorado.

***This accounts for all but 11 of these patients discharged from the Psychiatric Division during the first two years. These 11 were transfers from the Alcoholic Division. Because of the complications involved in analyzing their stay, they were omitted from the present analysis.

attendance at the center. The number of calendar days spent in 24-hour care, day care, evening care, family care and outpatient status are included in this statistic.

TABLE 1

TOTAL LENGTH OF STAY FOR PSYCHIATRIC PATIENTS DISCHARGED FROM FORT LOGAN IN ITS FIRST TWO YEARS OF OPERATION

NUMBER OF PATIENTS	TOTAL DAYS ON BOOKS	AVERAGE DAYS ON BOOKS
395	48,132	121.9

Patients may be admitted to a variety of services at the Fort Logan Mental Health Center. Table 2 summarizes the relationship between admission status and length of stay.

TABLE 2

LENGTH OF STAY BY ADMISSION STATUS

ADMISSION STATUS	NO. OF PTS.	TOTAL DAYS ON BOOKS	AVERAGE DAYS ON BOOKS
Inpatient Care	150	15,963	106.4
Day Care	236	31,220	132.3
Evening Care	4	367	91.8
OPD	5	582	116.4
Total	395	48,132	121.9

The data of Table 2 indicate that, contrary to our expectations, patients admitted to day care use the facilities of the center longer than those admitted as inpatients.

Not enough patients have yet been admitted to evening care and OPD to come to a meaningful conclusion about their length of stay.

In order to further explore the difference in length of stay between patients admitted to day care and patients admitted to 24-hour care, Tables 3 and 4 indicate how patients admitted to these facilities spend their time at the center.

The fact that not every patient used every possible modality accounts for the varying numbers of patients under the heading "Number of Inpatients Using Modality."

TABLE 3

USE OF TREATMENT MODALITY BY PATIENTS ADMITTED TO INPATIENT CARE

MODALITY	NO. OF INPATIENTS USING MODALITY	TOTAL DAYS ON BOOKS	AVERAGE DAYS
Inpatient Care	150	6,713	44.8
Day Care	83	4,910	59.2
Evening Care	3	117	39
Halfway House	1	22	22
OPD	40	3,909	97.7
Family Care	4	292	73
Total Admitted to Inpatient Care	150	15,963	106.4

Tables 3 and 4 reveal that the longer average length of stay for those admitted as day patients is related primarily to the greater length of time they spend in OPD and day hospital. Several possibilities present themselves as explanations for these differences. Each team has 14 inpatient beds at its disposal, but no such limitation exists for day care facilities. When a patient is admitted as an inpatient, therefore, there is greater pressure for fast disposition than when the same patient is admitted to day care. In addition,

the staff has greater exposure to the patient and gets to know him faster. As a result of the first of these factors, it seems feasible that the patient admitted to 24-hour care would be more rapidly transferred to another facility, or discharged. Earlier contact with community resources would shorten length of stay in both day care and OPD, and the staff's greater familiarity with the patient may allow them to feel more comfortable with earlier discharge from either day care or OPD.

TABLE 4

USE OF TREATMENT MODALITY BY PATIENTS ADMITTED TO DAY CARE

MODALITY	NO. OF DAY PATIENTS USING MODALITY	TOTAL DAYS ON BOOKS	AVERAGE DAYS
Inpatient Care	27	817	30.3
Day Care	236	22,959	97.3
Evening Care	4	143	35.8
Halfway House	1	10	10.0
OPD	54	7,010	129.8
Family Care	4	281	70.2
Total Admitted to to Day Care	236	31,220	132.3

Because most state hospital length of stay figures do not include time spent as outpatients, we did one further analysis by deducting the time spent as outpatients and recalculating the the average length of stay figures. Table 5 summarizes these data for the whole group and by admission status for inpatients and day patients.

TABLE 5

LENGTH OF STAY EXCLUDING TIME SPENT IN OPD

ADMISSION STATUS	NO. OF PTS.	TOTAL DAYS ON BOOKS	AVERAGE DAYS ON BOOKS
Inpatient Care	150	12,054	80.4
Day Care	236	24,210	102.3
Total Group*	395	36,517	92.4

*Includes admissions to Evening Care and OPD.

It should be noted that all of the length of stay statistics reported in the above tables refer to calendar days of attendance rather than number of days during which treatment was received. Thus, for example, most inpatients spend a significant proportion of their weekends at home, day patients vary in their attendance from five days per week to one day or less per week, and the intervals between outpatients' visits vary widely. Lengths of stay reported in the above tables would be significantly lower if reported in treatment days rather than calendar days.

On the other hand, since this report covers only the discharges from the Fort Logan Mental Health Center in the first two years of its operation, it seems likely that the length of stay figures will rise as patients have a chance to stay longer.

SUMMARY

The average length of stay for patients discharged during the first two years of operation of the Fort Logan Mental Health Center is 122 calendar days. If time spent as outpatients before discharge is deducted, the average drops to 92 days.

The total calendar length of stay for patients admitted as day patients is longer than the length of stay of patients admitted as inpatients, the major difference being in the greater time spent by

the day care admissions in day care and as outpatients. Some hypotheses explaining these differences are put forward.

While these figures compare favorably to those from other state hospitals (1, 2, 3), we realize that they must be continually revised because of the short history of our institution. It seems likely that they will tend to increase somewhat as patients have a chance to stay longer. Future reports will study other factors that relate to length of stay.

REFERENCES

1. CHITTICK, R. A., BROOKS, G. W., and DEANE, W. N., "Research Conference on Therapeutic Community," H. C. Denber, ed., Springfield, Charles C. Thomas, pp. 19-28, 1960.

2. KRUPINSKI, J. and STOLLER, A., "Survey of Institutionalized Mental Patients in Victoria, Australia, 1882 to 1959," Medical Journal of Australia, Vol. 49 (1), pp. 359-367, 1962.

3. MC WALTER, H. S., MERCER, M. S., and WATT, A., "Outcome of Treatment of Schizophrenia in a Northeast Scottish Mental Hospital," American Journal of Psychiatry, Vol. 118, pp. 528-533, 1961.

BOOK REVIEW

SOCIAL PSYCHIATRY: IN THE COMMUNITY, IN HOSPITALS AND IN PRISONS. By *Maxwell Jones, M.D.* Springfield, Illinois, C. C. Thomas, 1962, pp. 129. $5.75.

There is no consensus on the definition of social psychiatry, but the term is generally associated with a focus on social factors in the origin and treatment of mental illness and an emphasis on group rather than individual therapy. The term has achieved popular acceptance only in the last few years, and it is perhaps significant that Maxwell Jones' first book, which was published in England in 1952 under the title *Social Psychiatry*, appeared in the American edition as *The Therapeutic Community*. In this decade Jones has moved from the confines of the hospital to the wider horizons of the community and the prisons.

The author is no staid armchair theoretician. He draws on a wealth of practical experience, and whether he is discussing decentralization of a hospital or community therapy, he brings a critical eye to bear on both advantages and disadvantages. There are many cautions for the enthusiast who would go to extremes. Thus he warns against handing over ultimate responsibility to the patients: "In no sense does the staff or doctor in charge relinquish his ultimate authority which merely remains latent to be invoked when necessary."

A provocative writer, he does not hesitate to speak his mind, and there is frank criticism, for example, of the Veterans Administration and of the final report of the Joint Commission on Mental Illness and Health. He wonders whether there is any necessity for the nursing supervisor role and sharply questions present methods of teaching psychiatry in medical and nursing schools. The wide range of inquiry deserves an index, but the reader must fashion one for himself.

It is always difficult to evaluate the work of pioneers, to determine to what extent their success is a measure of their drive and enthusiasm. Whatever the judgment of time on social psychiatry, there can be little question that Jones has drawn attention

to a neglected aspect of treatment--the community within the hospital and the community to which the patient must return.

JOHN M. MACDONALD. M.B., F.R.C.P.(E)
Associate Director, Inpatient Service
Colorado Psychopathic Hospital
4200 East 9th Street
Denver, Colorado

NOTICE TO CONTRIBUTORS

The *Journal of the Fort Logan Mental Health Center* invites contributions in the areas of milieu therapy, social psychiatry, and related fields.

Manuscripts should be submitted in triplicate in the form in which the author wishes the paper to appear. Copy should be double-spaced, with margins of at least one and one-fourth inches.

References should be indicated by numbers in parentheses that refer to the list of references at the end of the article. The list should be alphabetical, and the names of the journals should not be abbreviated. The following format should be observed:

JAHODA, MARIE, "Current Concepts of Positive Mental Health," New York, Basic Books, 1958.

RIESMAN, D., "Some Observations on Interviewing in a State Mental Hospital," Bulletin of the Menninger Clinic, Vol. 23, pp. 7-19, 1959.

The author should include an address to which inquiries regarding the article should be sent, in the form of a footnote indicated by an asterisk on the first page of the article.

Manuscripts should be addressed to Paul Polak, M.D., Editor, Journal of the Fort Logan Mental Health Center, Box 188, Fort Logan, Colorado. Reprints will be furnished at the author's expense.